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Health Care News

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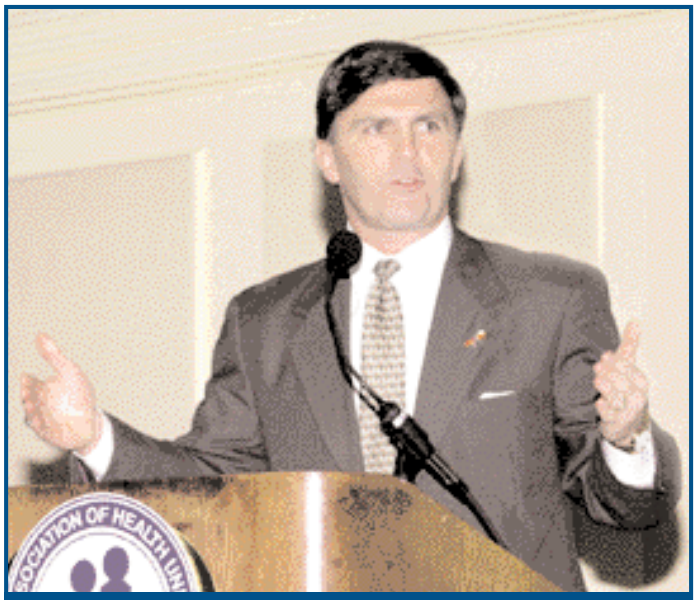

Congressman Robert Ehrlich (R-Maryland) addresses insurance brokers and agents at the National Association of Health Underwriters' conference in February. Photo: James Tkatch/ www.tkactchphoto.com. For more, see pages 10-11.

# Supreme Court Narrows Reach of ADA

## *Toyota decision represents an example of good facts leading to good law*

**BY DEWEY CREPEAU**

On January 8, 2002, the United States Supreme Court reached a landmark decision in the ongoing "debate over definitions" that is the Americans with Disabilities Act.

In *Toyota Motor Manufacturing, Kentucky, Inc., v. Williams*, Justice Sandra Day O'Connor delivered the opinion for a unanimous Court. O'Connor helped define what sorts of disabilities properly trigger an ADA complaint when she wrote,

" ... the Court of Appeals appears to have disregarded the very type of evidence that it should have focused upon. It treated as irrelevant '[t]he fact that [respondent] can ... ten[d] to her personal hygiene [and] carr[y] out personal or household chores.' *Ibid.* Yet household chores, bathing, and brushing one's teeth are among the types of manual tasks of central importance to people's daily lives, and should have been part of the assessment of whether respondent was substantially limited in performing manual tasks."

### Background

The suit was brought by Ella Williams, who worked on a Toyota auto assembly line using pneumatic tools beginning in 1990. She developed carpal tunnel syndrome in both wrists. When the condition was brought to Toyota's attention, Williams was assigned to "various modified-duty jobs."

Williams nevertheless filed an ADA suit against Toyota. That matter was settled, and she was placed in and performed a job satisfactory to both her and Toyota.

A couple of years later, Toyota changed her duties. She developed additional medical problems affecting her upper body and extremities. Advised by her doctor not to do any kind of work, she last worked on December 6, 1996. On January 27, 1997, she received a letter from Toyota that terminated her employment, citing her poor attendance record.

Williams responded by filing a charge of disability discrimination with the Equal Employment Opportunity Commission (EEOC). After receiving from the EEOC a "right to sue" letter, she filed suit against Toyota in the United States District Court for the Eastern District of Kentucky, alleging Toyota had violated the ADA and the Kentucky Civil Rights Act by failing to

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# Health Care Spending Rockets Upward

**BY CONRAD F. MEIER**

Hit by a recession and double-digit increases in health care costs, employers are taking aggressive steps to control their medical spending. Consumers are being asked to pay more for their medical care and take more responsibility for their care.

New health plans require employees to pay for in-office doctor visits, as well as increased co-pays and deductibles, making routine office visits appear more expensive than they've been in the past.

Most workers haven't seen dramatic increases yet, because many companies locked in insurance rates for 2002 last summer, when a quick economic recovery seemed more likely. But more will feel the pain in 2003, industry analysts believe.

### Health Care Inflation Returns

Health costs will rise nearly 13 percent on average, the fastest clip in a decade, and up from about 11 percent in 2001, according to a recent nationwide survey of 2,800 employers by benefits consultant William M. Mercer. By contrast, consumer prices generally increased at

SPENDING continued on page 17

# Bush FDA Nominee Stirs Controversy

**BY CONRAD F. MEIER**

President George W. Bush is traveling a bumpy road as he tries to fill the position of FDA commissioner, which has been vacant since Commissioner Jane Henney resigned in January 2001.

According to media reports, legislators and drug industry executives have criticized Bush for not putting a higher priority on filling the vacancy.

### Between a Rock and a Hard Place

Bush appears to be facing a no-win situation. If he names a candidate from the pharmaceutical industry, he raises the ire of Senate Democrats. A nominee from outside the industry could upset pharmaceutical companies, who supported Bush's election.

The controversy has already beached one possible candidate. In July 2001, the administration put forward the name of Michael Astrue, general counsel for the Cambridge, Massachusetts biotech company, Transkaryotic Therapies.

Seven Democratic Senators, including Edward Kennedy (D-Massachusetts), chairman of the Senate Health, Education, Labor and Pensions Committee, gave the nominee two thumbs down. Kennedy vowed he would not hold confirmation hearings if Astrue were nominated.

According to a report published by American Health Line in October last year, Kennedy's opposition surprised White House

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# CAPITOL HILL NEWS WATCH

## HHS Releases $200 Million in Bioterrorism Funds

**BY CONRAD F. MEIER**

Health and Human Services (HHS) released the first $200 million of a $1.1 billion plan to improve bioterrorism preparedness in hospitals and state and local health agencies—an effort to help "transform the overlooked science of public health" into the nation's "first line of defense" against a bioterrorist attack, the *Washington Post* reports.

States are supposed to use the funds to train medical and emergency personnel to identify and respond to bioterrorist attacks, improve public health laboratories, upgrade computer systems, and prepare hospitals to treat a "huge influx of sick or injured," according to the *Baltimore Sun*.

State and local health departments received about $175 million of the funds, and hospitals received about $25 million. The state awards are based on population. According to a breakout of funds provided by the *Baltimore Sun*, California received the largest share of the funds, at $69.7 million, while Wyoming received the least, $6.5 million. Four cities—Los Angeles, New York, Chicago, and Washington, DC—also received funds.

HHS Secretary Tommy Thompson said in an AP news report, "We now have the opportunity to build a viable, vibrant, strong local and state public health system that will prepare and protect our citizens for any attack that may come."

According to HHS, the states may begin spending their first installment immediately, but they must submit "comprehensive" plans to improve their "core" public health systems to HHS by March 15 to receive their remaining shares of the $1.1 billion.

HHS further requires states to develop plans to prepare hospitals for "mass-casualty incidents," track "suspicious" diseases, expand health laboratories, and increase communication between the health care industry, local health officials, and federal agencies.

HHS will review each plan within 30 days and release the rest of the state's money when a state plan is approved. Thompson has said his agency "will not be heavy handed on it. [We] just want to make sure the money is well-spent."

## *Good News and Bad in State of the Union Address*

**BY GRACE-MARIE TURNER**

Following President George W. Bush's State of the Union address, delivered on January 29, there's been a whirlwind of news about the administration's health policy initiatives. Among the highlights:

• Twice in his State of the Union address, Bush called attention to his plan "to give uninsured workers credits to help buy health coverage," making the issue a top domestic policy priority. The White House and allies on Capitol Hill believe they have a winning idea to extend private health insurance to millions of Americans currently shut out of the system. The President will put $89 billion in his budget for the credits.

• The Bush plan also would loosen the choking regulations on Medical Savings Accounts, making them available to millions more Americans. He also would end the indefensible use-it-or-lose-it provision for job-based health spending accounts and allow workers to roll over up to $500 a year tax-free. This is all good.

• Then the President turned to Medicare, saying he wants Congress to help him "give seniors a sound and modern Medicare system that includes coverage for prescription drugs." The rhetoric was fine ... but then the White House released details of the proposal.

The White House plan would give waivers and extra money to states to expand drug-only coverage to seniors and the disabled through Medicaid, the joint federal-state health care program for the poor. The plan does not advance the President's stated goal of a Medicare system with an integrated drug benefit.

The Medicaid expansion will only exacerbate the massive problems states are already having with Medicaid expenses that are gobbling up their budgets. And it will put millions of senior citizens into an entitlement program that is developing many of the restrictions and price controls that burden all other government-controlled health programs. Medicaid expansion moves away, not toward, market-based reform.

• And finally, the President said again he wants a patients' bill of rights enacted this year.

A new Bureau of Labor Statistics report reveals the burden employers already face with rising benefit costs. Those data clearly show what a bad idea the PBOR bill would be, especially now.

For the last five years, according to the BLS, wages and salaries have risen at a consistent rate of about 3.5 percent a year. Benefit costs rose at a slightly lower rate of 2.0 to 2.5 percent a year from 1996-98. But in the last two years, the rate of increase in benefit costs has more than doubled, to more than 5 percent a year.

Clearly, benefit costs are outstripping wage and salary costs. This is not the time to impose more costs on employers with an expensive patients' bill of rights.

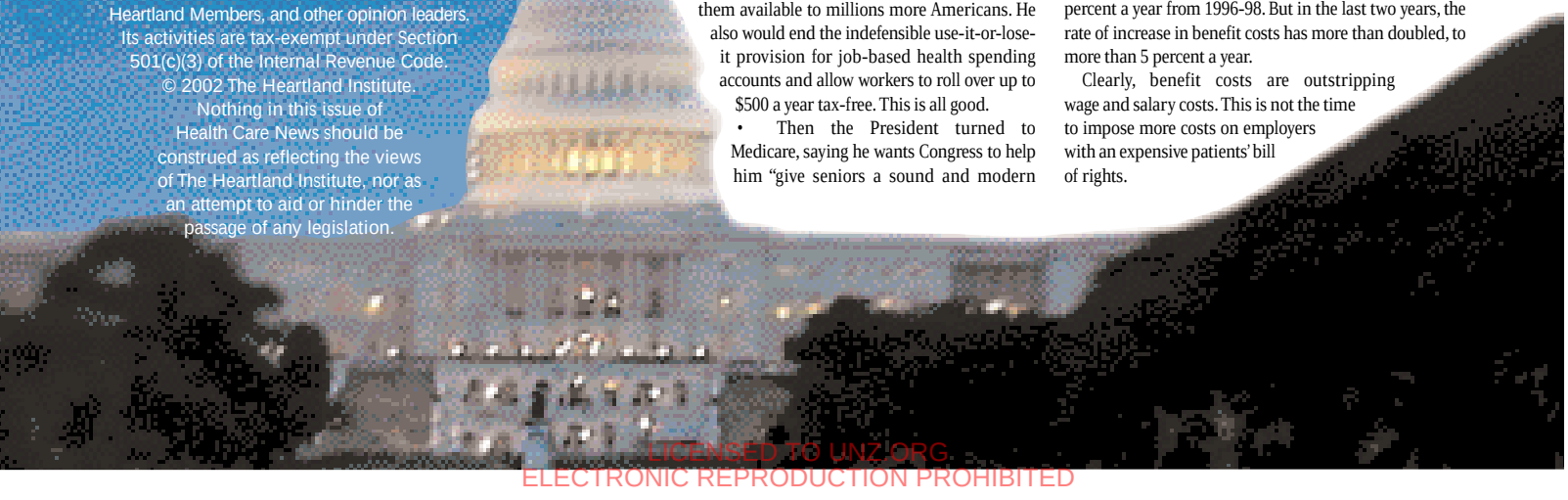
### For more information...

**WWW** The full text of the President's State of the Union address is available on the Internet at **http://www.whitehouse.gov/news/releases/2002/01/20020129-11.html**

A Department of Health and Human Services press release describing the President's budget can be found at **http://www.hhs.gov/news/press/2002pres/20020130.html**

A White House fact sheet on strengthening Medicare is available at **http://www.whitehouse.gov/news/releases/2002/01/20020128-14.html**

The Bureau of Labor Statistics' new employment cost index is on the Internet at **http://www.bls.gov/news.release/eci.nr0.htm**



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# The Pulse

## Free-market health care reform in the news

BY GREG SCANDLEN

You are invited to participate in an online discussion list dealing with many of the issues we report on here. To check it out, send an e-mail to HealthBenefitsReform-subscribe@yahoogroups.com. Later on, if you want to drop off, just send an e-mail to HealthBenefitsReform-unsubscribe@yahoogroups.com.

### Republican Opportunities in Health Care

At a recent meeting on Capitol Hill, Bob Moffit of The Heritage Foundation encouraged Republican officials to take the offense on health reform.

He said they should press the advantage revealed during the debate on the stimulus package. During the debate, the Republicans clearly had the better position, calling for tax credits for all workers without employer-sponsored coverage.

The Democrats were on the defensive, offering a weak-kneed proposal for huge financial support for those few workers eligible for COBRA, and putting everyone else on Medicaid. Moffit said this opportunity to change public perceptions is too important to squander.

An article in *USA Today* bears him out. A recent USA Today/CNN/Gallup poll found the Republican Party has gone from a nine-point deficit to a six-point advantage over Democrats since September 11. Currently 61 percent have a favorable view of the Republicans and 55 percent have a favorable view of the Democrats.

The Republicans do especially well on defense, fighting terrorism, and foreign policy. They also do better on taxes, the economy, and the federal budget. The big weakness for Republicans was in health care, where the Democrats held large advantages on issues like prescription drugs in Medicare, Medicare reform, and the Patients' Bill of Rights.

If Republicans can roll out an aggressive health care agenda, the Democrats wouldn't have any issues left.

*Source*: http://www.usatoday.com/news/2002-01-15-usat-poll.htm

### Congressional Staff Out of Touch

Unfortunately, Congress is still focused on issues like the Patients Bill of Rights and prescription drugs for Medicare, according to an article by Julie Rovner in Reuters.

She reports on a Congressional staff panel discussion at the National Health Policy Conference, which also discussed such burning issues as cloning.

Largely absent from the discussion were the issues that are really on people's minds these days, such as premium increases, the collapse of managed care and the small group market, the growth of consumer-driven health plans, the problems with Medicaid and SCHIP, and the cost of complying with all of Congress's regulations.

In fact, Dean Rosen, health advisor to Senator Bill Frist (R-Tennessee), is quoted as praising HIPAA and the BBA as great bipartisan successes. Has Washington ever been more out of touch?

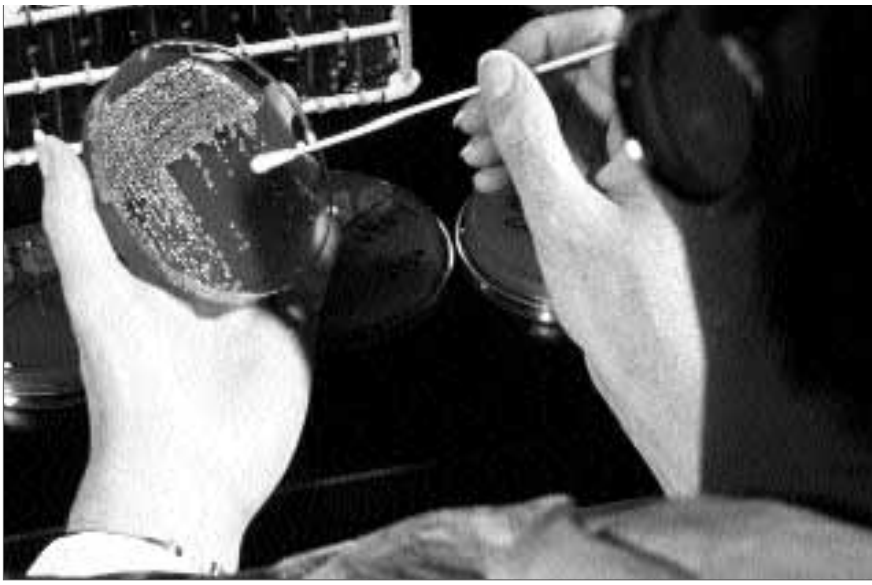
*Source*: http://www.reutershealth.com/frame2/eline.html (look for the January 17 stories)

### Hawaii Legislators to Make Bad Problems Worse

Perhaps no state is in a bigger health care mess than Hawaii, the one state with an ERISA waiver allowing the state to mandate employer-provided coverage.

The "Prepaid Health Care Act" requires that workers pay no more than 1.5 percent of their wages for their share of the cost of coverage. But premiums have increased much faster than wages, so the employee contribution now amounts to only 7 percent of the cost—compared to 30 percent of the cost when the law was passed in 1974. Curiously, the state itself pays only 60 percent of the cost for state employees, with state workers paying the other 40 percent.

Naturally there are consequences. People who work only 20 hours a week are exempt from the law, so many companies employ only part-time workers, and unemployment is high. The act also requires a single benefit design, which has helped create a near-monopoly among health insurance providers. The Hawaii Medical Service Association (the local Blue Shield plan) has the bulk of the market with a local Kaiser plan taking almost all the balance.



This near-monopoly has given the insurance commissioner the excuse he needs to demand new power to control premium rates. Commissioner Wayne Metcalf says "the health care plan marketplace is totally dysfunctional with virtually every competitor ... fallen by the wayside in the last several years."

Rather than opening up the market, many legislators in Hawaii are looking in exactly the opposite direction. The chairman of the Health and Human Services Committee has proposed a "universal reimbursement fee schedule" that would require all payers—including auto, workers' comp, and health plans—to pay providers at 120 percent of the Medicaid rates.

Another legislator wants to create a "universal long-term care insurance plan" that would require all adults over age 25 to pay for LTC coverage.

*Source: This information is based on a series of articles by Kristen Sawada in* Pacific Business News. *See*: http://pacific.bcentral.com/pacific/stories/2002/01/21/story8.html http://pacific.bcentral.com/pacific/stories/2002/01/07/story3.html http://pacific.bcentral.com/pacific/stories/2002/01/14/story3.html

### Self-Insured Employers Hurting, Too

Things aren't a whole lot better for self-insured employers, according to an article in *Employee Benefit News*. Premiums for stop-loss reinsurance are going up 40 percent to 50 percent, partly because of the losses reinsurers experienced on September 11, and partly because of several major companies leaving the market, according to Don Gasparro.

He says employers are responding by moving to defined contribution solutions as well as partnering with other players to help assure greater efficiency of their health care dollar with quality assurance programs, performance audits, and better employee education.

*Source*: http://www.benefitnews.com/subscriber/Article.cfm?id=37880513

### Consumer-Driven Plans in Austin

Amy Schatz writes a story in the *Austin American Statesman* about some of the new health plans available in Central Texas, including those of Lumenos, Destiny, Aetna, Humana, and United Healthcare.

In a bit of a twist, Schatz says, "Consumer groups are concerned that health care providers aren't prepared for the kind of scrutiny that defined-contribution plans would bring upon them." She also says "insurers are keen to break the perception that a doctors visit costs $10," and quotes Scott Keyes, a Watson Wyatt consultant, who says, "We've got a generation of people who have gotten used to the idea that health care doesn't cost anything."

*Source*: http://archives.statesman.com/ January 20, 2002

### Consumer-Driven Plans in Rhode Island

The *Providence Journal-Bulletin* is interested in "a whole new world of health care," too. It focuses on local company Textron, which has adopted Definity's health plan. Out of 1,700 local employees, 1,320 have signed up for the plan as of January 1, 2002.

Most of the rest get coverage from their spouses or other family members. Because the Textron program is so new, the article looks at the experience of Medtronics, which also has a Definity program. If the approach works, Textron intends to offer it to all of its 36,000 employees.

*Source*: http://archives.projo.com/ January 16, 2002

### Consumer-Driven Plans Get Cynical Response

A more cynical view is offered by Stacey Bradford in SmartMoney.Com. It isn't that she says anything inaccurate or even especially critical. It is more that she uses a condescending tone that dismisses the favorable aspects and lends credence to the critics.

"Forewarned is forearmed," she says, "these newfangled plans ... are coming your way."

"To its proponents, these plans represent the Holy Grail of health-care cost containment," she writes.

Essentially, the article is an example of how difficult it will be for some people to become accustomed to the idea that health care isn't free, and that having consumers involved in the cost of their care is not an evil plot.

*Source*: http://aol.smartmoney.com/consumer/index.cfm?story=20020124

*Greg Scandlen is senior fellow in health policy at the National Center for Policy Analysis in Dallas, Texas and assistant editor of* Health Care News. *To sign up for his free weekly e-newsletter,* Scandlen's Health Policy Comments, *log on to www.ncpa.org/sub. Scandlen can be reached by email at GMScan@aol.com.*

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# High-Risk Pools Insure the Uninsurable

## *31 states serve the medically risky without over-regulating private insurers*

**BY CONRAD F. MEIER**

Approximately 2.5 million people in the U.S.—about 1 percent of the population—suffer from pre-existing medical conditions that make it likely their future medical expenses will be extremely high.

While private insurers are ill-equipped to serve this population, 31 state governments play a positive role by chartering nonprofit high-risk health insurance plans, or HIPs. In order to keep premiums affordable, HIPs are often authorized to impose a small assessment on the premiums earned by private insurers.

HIPs accomplish the social goal of assuring access to quality medical care for those who need it, without the disruptions and negative side effects caused by regulation of the insurance industry.

### A Right Way and a Wrong Way

Some states are attempting to ensure access to medical care for the medically uninsurable simply by forcing companies that sell individual health insurance to write policies for them. By doing so, those states are creating serious problems for the vast majority of their residents who do not suffer from medically uninsurable conditions. Studies show such regulations increase premiums, increase the number of uninsureds in a state, and do serious damage to the insurance marketplace.

The Council for Affordable Health Insurance (CAHI) uses the image of an inverted pyramid to illustrate the problem. "The people in the individual market comprise a very small area at the bottom of this inverted pyramid. To force that small group of people to fund the burden of all of the uninsurable people coming from the rest of the pyramid [large groups, small groups, self-funded programs, government programs, etc.] simply cannot work because it requires a price that is far too high for this market to bear."

When financed by small assessments on the premiums paid to private group insurers, HIPs spread the cost of covering uninsurables across a much larger base of insureds. The result: accomplishing the social goal of assuring access to quality medical care for those who need it, without the disruptions and negative side effects caused by heavy-handed regulation of the insurance industry.

### Private-Sector Solutions

Many insurance companies, including Golden Rule, Mutual of Omaha, and Fortis Health, support the concept of high-risk pools as an effective safety net for individuals with chronic health conditions. Risk pools provide private insurance coverage alternatives to those who would otherwise need to depend on public assistance programs or simply go uninsured.

Ben Cutler, president and CEO of Fortis Health, said in a company press release, "Fortis Health is committed to working for change in states where regulation has created an unfavorable insurance climate for consumers and insurers alike." Cutler also says his company has never abandoned a state due to competition, but has been regulated out of business where health care reform legislation has made it impossible to co-exist with over-regulation.

### Success in Kentucky . . .

The combination of community rating, price controls, standardized benefit packages, guaranteed issue, and patient access laws created chaos in Kentucky's health care system. In response, most health insurance companies were eventually forced out of doing business in the state.

> **"[C]ommunity rating, price controls, standardized benefit packages, guaranteed issue, and patient access laws created chaos in Kentucky's health care system ... and most health insurance companies were eventually forced out of doing business in the state."**

In turn, thousands of people were left without competitive buying choices. This resulted in dramatically higher insurance premiums, which created historically high uninsured statistics. (See "How Kentucky Destroyed Its Health Insurance Industry (and a Plan to Rescue It)," a *Heartland Perspective* by Conrad F. Meier, January 13, 1998.)

To address the problem, the state launched Kentucky Access, a new high-risk pool that started enrolling eligible residents on January 1, 2001. Within five months, the plan had insured 351 qualified residents. By enrolling Kentuckians with known, high-risk medical conditions in a separate insurance pool, the state hopes to encourage private insurance companies to return to the state marketplace.

### . . . and New Hampshire

New Hampshire Senator Arthur P. Klemm (R-District 22) announced "the New Hampshire Senate passed legislation to restore a healthy market for individual insurance. It involves the creation of a high-risk pool, funded through industry assessments, to subsidize coverage for people who are priced out of the regular market."

Klemm points out insurance carriers left the state after it passed regulations controlling the types of insurance policies insurers could offer. Since the new legislation was signed by Governor Jeanne Shaheen (D), many insurance companies have indicated they are favorably inclined to return to the state insurance market.

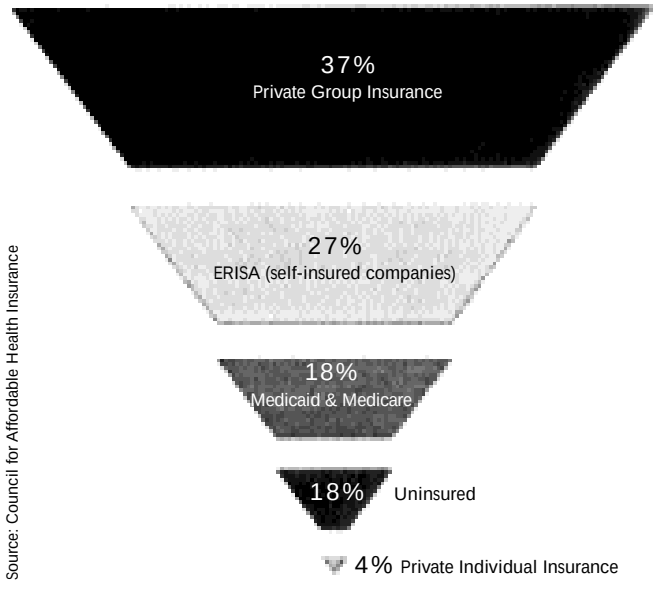
The new risk pool is currently in the organizational stage and a director has yet to be named. The state Department of Insurance estimates the pool will begin accepting applications as early as July 1.

### More High-Risk Pools Coming

Thirty-one states have implemented risk pools (only Florida's remains closed to new applicants), and several others are considering legislation to create them.

In October 2001, Golden Rule and Fortis Health addressed attendees at the annual meeting of the National Association of State Comprehensive Health Insurance Plans (NASCHIP)—the sole organization providing resources, advocacy, and educational programs for states with individual market high-risk pools.

In addition to their leadership on high-risk pools and other state reform initiatives, Golden Rule, Fortis Health, and Mutual of Omaha have been prominent at the federal level on a number of issues. Golden Rule is frequently mentioned as the originator and leading expert on Medical Savings Accounts; Fortis is spearheading defined-contribution plans; and Mutual of Omaha gets credit for creating and developing the high-risk pool concept over 25 years ago.




**The individual insurance market is too small to cover uninsurable individuals coming out of all other types of insurance.**

## When it Comes to Health Care, You *Can* Insure a Burning House

**BY LEE TOOMAN**

Jane is 58 years old and lives in Florida. She saved up a significant retirement nest egg and decided to take early retirement. Even though she was offered COBRA continuation of her health insurance coverage, she did not act on it.

Now, just a few weeks after her time to sign up for COBRA expired, her doctor told her after a routine check-up that she has become diabetic. Jane tried to buy private, individual health insurance, but discovered she is no longer insurable. She tried to go back and sign up for COBRA, but it was too late.

Jane found out the hard way that she has to go back to work so she can get coverage under a group health insurance plan.

Now consider a different case. Mary is just like Jane ... with one important difference: Mary lives in Indiana. Even though her medical condition means she cannot qualify for private individual health insurance, she does qualify for the Indiana Comprehensive Health Insurance Association, or ICHIA.

ICHIA is a high-risk pool designed for uninsured people who are also medically uninsurable. Thanks to ICHIA, Mary qualifies for high-quality, major medical health insurance, regardless of her health. She will pay a penalty for dropping out of the insurance system—her premium will be up to 50 percent higher than for comparable insurance outside the risk pool—but she will not be uninsured.

### Risk Pools Work

High-risk pools like ICHIA operate in 28 states. More than 127,000 people are insured by them. Best of all, the pools are usually administered and financed by the private health insurance industry, not government.

According to Communicating for Agriculture's recent report, *Comprehensive Health Insurance for High-Risk Individuals*, the typical person insured in a high-risk pool generates $5,272 in annual claim cost. But the aver-

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# A Proposal to Create Personal and Portable Insurance in Texas

*Managing editor's note*: In the February 2002 issue of *Health Care News*, we presented a discussion of Texas' uninsured problem written by John C. Goodman of the National Center for Policy Analysis.

Here, Goodman offers a brief outline of a proposed solution to the uninsured problem in Texas ... and nationwide.

**BY JOHN C. GOODMAN**

How can the purchase of health insurance be changed to allow greater consumer satisfaction with the health care coverage? This is a proposal to combine the advantages of individual insurance with the advantages of group insurance and avoid the disadvantages of both. This new, hybrid form of insurance will be called New System Plans (NSPs). Employers who assist their employees in entering NSPs through the payment of premiums will be called Defined Contribution Employers (DCEs).

### Advantages, Disadvantages of Group Insurance

The advantages of group insurance are

- premiums are paid with pretax dollars;
- economies of scale in purchasing; and
- avoidance of the costs of underwriting.

However, because such contracts are typically only one year in duration, the insureds have no reasonable expectation that if they get sick they will be able to see the same doctor or remain in the same network the following year. Employers can choose a different plan with different benefits and different provider networks. Also, employees eventually lose the right to continue participation in the plan if they quit work or are fired.

### Advantages, Disadvantages of Individual Insurance

The advantages of individual insurance are

- guaranteed renewability (once in a health plan, insureds have the right to remain there indefinitely);
- premium increases reflect the costs of the plan as a whole and not the changes in health status of individual members; and
- the insurance is portable (unaffected by job changes).

The disadvantages of individual insurance are

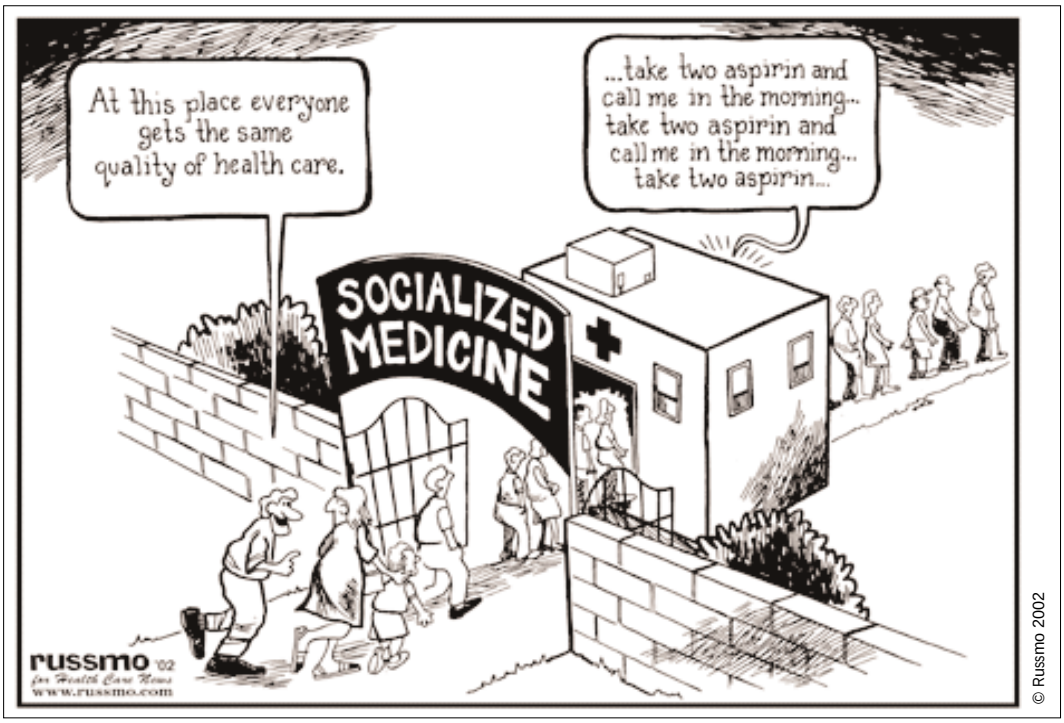
- premiums must be paid with after-tax dollars (except for a partial deduction for the self-employed);
- higher administrative costs; and
- the costs of medical underwriting.

### Best of Both Worlds

Texas law should be changed to allow employers to buy personal and portable insurance for their employees. Even though employers initially would pay the premiums (as they do today), this insurance would be owned by the employees and would travel with them as they move through the labor market. Thus employees would get portable insurance (a characteristic of individual insurance), but they would get it at premiums that are closer to the norms of group insurance.

Although it is envisioned that employers initially will buy all their employees into the same NSP, with the passage of time some of those employees will leave and go to work for other firms. Employers will also hire new employees who are members of other NSPs. And, in most cases, the employer's initial group of employees will be able to switch to other NSPs after a transition period.

The typical defined contribution employer, therefore, can eventually expect to have employees in different NSPs. Indeed, it is possible that every employee will be in a different NSP.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age annual premium is only $2,915. The difference—that is, the loss—is picked up and paid generally by the health insurance industry, based on each carrier's market share.

Premiums charged to persons insured in high-risk pools are relatively affordable. Most pool rates are capped at a percentage of the average price charged for comparable coverage by the private market. In Indiana, for example, the cap is 150 percent. So, if the average private rate is $200 per month for comparable coverage, the pool's rate would be $300 per month. That's a bargain for people who are both uninsured and uninsurable (and who may not have paid any health insurance premiums for many years).

Most plans in the private health insurance market feature deductibles, copays, limits on certain coverage, and lifetime maximums. The Health Insurance Association of America points out in its *Source Book of Health Insurance Data*, "Almost all policies include a deductible, which usually ranges from $100 to $300 for an individual or $500 or more for a family. Most fee-for-service policies reimburse doctors at 80 percent of the reasonable and customary charge (the prevailing cost of a medical service in a given geographic area), and the patient pays the remaining 20 percent.

"Most policies have an out-of-pocket maximum. In a given year, if expenses exceed a specified level, the patient's coinsurance is waived, and the insurer pays the doctors' fees in full.

> **"[T]he typical person insured in a high-risk pool generates $5,272 in annual claim cost. But the average annual premium is only $2,915."**

Many fee-for-service arrangements cover 100 percent of hospital bills; some reimburse at the 80:20 ratio. Lifetime limits stipulated in a fee-for-service policy sometimes put a ceiling on the total claims paid."

Risk pools are no different. People can purchase $500 annual deductible plans in 19 risk pools and $1,000 annual deductibles in every pool. Twenty of the states' plans include lifetime maximums of $1 million or more, five offer plans with unlimited lifetime maximum benefits, and none has less than a $350,000 maximum benefit. Most, according to Communicating for Agriculture, offer managed care options.

None of the plans exclude coverage for preexisting conditions longer than 12 months, and 20 exclude coverage for six months or less. Several of the pools waive this exclusion altogether if the person had recent, prior coverage. And no plan looks back more than six months to define a preexisting condition.

### Something about Mary

Let's take a look at Mary again. She lives in Kokomo, Indiana. She will be able to purchase a major medical plan with a $1,000 deductible for $535.29 per month. There will be no limit on the lifetime maximum benefit. If she had coverage within the last six months, she will not have a waiting period for coverage for her preexisting condition. Even if her prior coverage lapsed more than six months ago, she will have to wait only three months for coverage for preexisting conditions to begin.

The ICHIA major medical plan has coverage for outpatient care, inpatient care, surgery, prescription drugs, ambulance service, diagnostic tests, skilled nursing care, home health visits, transplants, rehabilitation, durable medical equipment, mental health and chemical dependency, physical therapy, speech therapy, occupational therapy, and preventative care. If she were younger, she would even have maternity coverage!

Because Indiana made a commitment to making health insurance available to every citizen, Mary will get the coverage she needs. By contrast, Jane must foot her own bills or go back into the workplace to get health insurance.

Every state should enact a comprehensive health insurance plan for high-risk, uninsured persons. Coverage should be high quality, with rates capped and losses shared by every citizen.

*Lee Tooman is vice president of government relations for Lawrenceville, Illinois-based Golden Rule Insurance Company.*

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# State Legislative Update

**COMPILED AND EDITED BY CONRAD F. MEIER**

ARIZONA

Gov. Jane Hull (R) predicted spending on some programs for poor residents could exceed the state's ability to pay.

To address the possible shortfall, Hull said in her State of the State address, "Tough decisions need to be made and they need to be made now. Government cannot be all things to all people."

Hull also asked the state's Medicaid program, the Arizona Health Care Cost Containment System, to coordinate a statewide educational program regarding long-term care.

CONNECTICUT

Facing a $350 million budget deficit in this fiscal year, Gov. John Rowland (R) has cancelled plans to spend $14 million on mental health services in 2002-2003.

To cover this year's budget deficit, Rowland said he would consider increasing the state's cigarette tax to $1 a pack. Any revenue from the tax should support health care costs, he said, not anti-smoking programs.

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GEORGIA

In his budget for fiscal year 2003, Gov. Roy Barnes (D) has proposed eliminating a planned expansion of Medicaid coverage to children in families with annual incomes of up to 150 percent of the federal poverty level. Barnes had proposed $235 million to cover the expansion, but an increase in Medicaid costs prompted the governor to delay the expansion plan.

Barnes' budget also recommends cutting $2.5 million from the Babies Born Healthy program, which provides prenatal care to low-income women.

IOWA

In an effort to fund health care and education in 2002-2003 and cover a $48 million Medicaid budget shortfall, Gov. Tom Vilsack (D) has proposed using $48 million from the state's "rainy day" fund and $60 million from a road-use tax fund.

To further bolster the Medicaid program's budget, Vilsack proposed a 13 percent reduction in reimbursements to Medicaid providers, as well as using money from the state's tobacco settlement and a trust fund designed to pay for health care for seniors. Vilsack's plan also relies on receiving $10 to $12 million in additional funding from the federal government.

KANSAS

In his State of the State speech, Gov. Bill Graves (R) lamented the budget he announced last month, with planned cuts of more than $400 million from the state general fund. Graves said, "It is not a budget I can or will accept."

During the speech, Graves announced a new budget, which would restore $3 million in mental health grants; $1.5 million in grants for developmentally disabled people; and $4.4 million in funding for the Senior Care Act, which gives seniors the opportunity to stay at home and "preserves the financial and personal dignity of [elderly] Kansans."

Graves offered no indication of where the money was coming from.

KENTUCKY

Gov. Paul Patton (D) has proposed a $14.4 billion budget, a two-year spending plan based on transferring funds from a variety of programs, including health care services.

For example, $49 million would be taken from Kentucky Access, the newly established high-risk insurance pool that provides health insurance to residents who are uninsurable in the private market. The state's Medicaid program faces a possible $200 million budget shortfall and could be subject to cuts in services.

MASSACHUSETTS

An 11 percent increase in funding for the state's Medicaid program was mandated by the federal government and would be paid for by delaying payments to the state's pension fund and a cutback on lottery prizes.

Acting Gov. Jane Swift's (R) fiscal year 2003 budget proposal would increase overall Medicaid program spending. Her plan also calls for the elimination of dental benefits.

Swift's budget plan also calls for cutting $50 million from public health outreach and education programs and $29 million from anti-smoking efforts. The budget proposal would cut $11 million from disease screening and prevention programs.

In her State of the State speech, Swift noted the state has been assisting in "the national effort to combat terrorism." Swift also announced the creation of a Bioterrorism Council, to be led by the state Director of Commonwealth Security.

*The Boston Herald* reported Swift's speech "was notable for the issues she glossed over," including rising prescription drug costs. Swift did acknowledge the state faces a health care crisis in the capital city and statewide.

NEW YORK

Gov. George Pataki's (R) $88.6 billion budget proposal for the fiscal year beginning in April includes a $3 billion increase in health care spending.

Much of the health care spending in Pataki's budget is based on a package that, in part, would pay for wage increases for union health care workers. The state legislature recently approved that package.

The increase in health care appropriations comes at the expense of other parts of the budget. Health care was protected from cuts by transferring money from other budget items.

The budget is also based on Pataki's assumption that the state will receive more than $800 million in federal Medicaid funds. HHS officials, however, have said that level of funding is not likely. Pataki also has said he wants to use $646 million of the state's $3 billion rainy-day fund.

WISCONSIN

Despite a $1.1 billion budget shortfall this year, Gov. Scott McCallum's (R) plan to balance the budget saves the $2.7 billion the state has earmarked for health and social service programs in this fiscal year and next.

No cuts were made to programs such as BadgerCare, which provides health insurance for low-income residents ineligible for Medicaid, and FamilyCare, which provides long-term care services.

In addition, McCallum's budget plan keeps $5.8 million in grants to the Marquette University Dental School and funds programs for women's health screenings, pregnancy counseling, and cancer screenings. McCallum's budget also protects Community Options and the Community Integration Program, two long-term care assistance programs.

McCallum's budget cuts the state's revenue-sharing program with cities and counties. This, in turn, may force localities to curtail programs for people with disabilities or the elderly.

*The State Legislative Update is compiled from a wide range of news sources, including the Council for Affordable Health Insurance (CAHI) http://www.cahi.org; the National Association of Health Underwriters (NAHU) http://nahu.org; Bizjournals at http://bizjournals.com; Stateline at http://stateline.org; and Lexis/Nexis research.*

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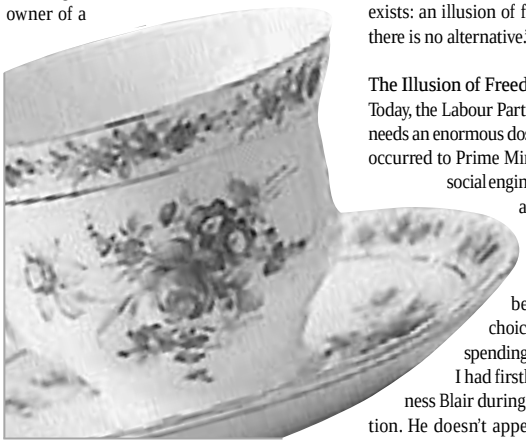
# English Health Care: Not Your Cup of Tea

## *Second in a series*

**BY CONRAD F. MEIER**

An Englishman I met while in Sheffield was most colorful when I asked him to describe the National Health Service (NHS). In a printable response he said, simply, "Hobson's Choice."

He quickly offered me an explanation: Seems as though Hobson was the owner of a stable of horses for hire. He developed a practice of always requiring every customer to take the horse closest to the barn door. When asked by a patron for a different horse, Hobson always replied, "take this horse or take nothing at all."



"Hobson's Choice" has evolved, according to *Webster's New International Dictionary*, to mean "the apparent freedom to take or reject something offered when in fact no such freedom exists: an illusion of freedom of choice where there is no alternative."

### The Illusion of Freedom

Today, the Labour Party line proclaims the NHS needs an enormous dose of tax money. It has not occurred to Prime Minister Tony Blair and his social engineers that the United States and most of Europe spend so much more on health care—and spend it so much more effectively—because consumers have choices and a right to private spending on health care.

I had firsthand opportunity to witness Blair during his campaign for reelection. He doesn't appear to be as socialist on health care as he really is. He walks a different walk, while talking the same old talk. His reform plans have been sliced and diced so many times by the London media, you can see right through them.

> **"The doctors, nurses, and businessmen I visited in England made clear that even the newest of the Labour Party thinkers still holds fast to a reverence for a state-run, state-funded system."**

The NHS reform measures are, from my perspective, all style and devoid of any consideration for consumer choice and privatization. The doctors, nurses, and businessmen I visited in England made clear that even the newest of the Labour Party thinkers still holds fast to a reverence for a state-run, state-funded system. That sort of tunnel vision creates an environment in which ideas supportive of consumer choice and free-market competition rarely get serious consideration.

The NHS is, as Hobson would have it, "an illusion of freedom of choice where there is no alternative."

Stephen Pollard, a senior fellow at the Centre for the New Europe in Brussels, agrees. "It doesn't matter how much you talk about management incentives and the importance of 'consumer focus,' or how many businessmen you ask to conduct 'reviews': the NHS was created to serve a society where rationing was the norm and the state was viewed as the ideal engine for growth. The rest of us have moved on.

"Labour's language may have changed," he notes, "but when it comes to the nation's health, its mind is stuck in 1948."

### Dysfunctional Bureaucracy

Judith Smith and Kieran Walshe, senior lecturer and senior research fellow, respectively, for the Health Services Management Centre at the University of Birmingham, write, "Governments often regard a degree of medical disapprobation as a sign that their NHS policies are generally heading in the right direction. However, NHS managers have traditionally been stalwarts of public service, implement-

HEALTH CARE continued on page 8

# *U.S. HMO Beats Britain's NHS*

**BY CONRAD F. MEIER**

U.K. Chancellor Gordon Brown took new Labour's biggest gamble when he said the way to give Britain a "world-class" health service is to increase future taxes.

According to Brown, "a significantly higher share of national income should be devoted to health care to correct decades of under-funding." Brown used the release of an independent report on long-term health demands to rule out extensions of private finance, declaring a publicly funded system would always be best for Britain.

According to projections by PricewaterhouseCoopers, taxes would have to rise by £10 billion—$14.5 billion—to restore the NHS to respectability.

But Kaiser Permanente, a California-based nonprofit health maintenance organization, shows money isn't everything.

According to a detailed study of the costs and performance of the two systems, the U.S. HMO has costs similar to those of the entire NHS system ... but the HMO performs considerably better. The report was produced for the Institute for Global Health at the University of California by the group's director, Richard G. A. Feachem, its CEO, Neelam K. Sekhri, and its programme development officer, Karen L White.

The adjusted costs of the two systems and their performance were compared on measures of inputs, use, access to services, and responsiveness, and a handful of quality indicators.

### Findings

The per-capita costs of the NHS, converted to U.S. dollars and adjusted for variations in benefits, special activities, demographics, and the single-payer environment, were just 10 percent less than Kaiser-Permanente's per-capita costs: $1,764 per person for the NHS, and $1,951 for Kaiser.

Yet the HMO's members receive more comprehensive and convenient primary care services and have much quicker access to consultant and hospital services than do patients who rely on the NHS's socialized medicine.

The difference is explained by better management, better use of integrated systems, greater investment in technology, and free-market competition.

> **"According to a detailed study ... the U.S. HMO has costs similar to those of the entire NHS system ... but the HMO performs considerably better."**

**For more information…**

**WWW** The report, "Getting More for Their Dollar: A Comparison of the NHS with California's Kaiser Permanente," is available on the Internet, in HTML and PDF formats, at the *British Medical Journal*'s Web site at **http://bmj.com/cgi/content/full/324/7330/135#Top.**

The analysis does not support a notion widely held and often repeated in the U.K.: that the NHS is efficient, and poor performance is explained by a lack of money.

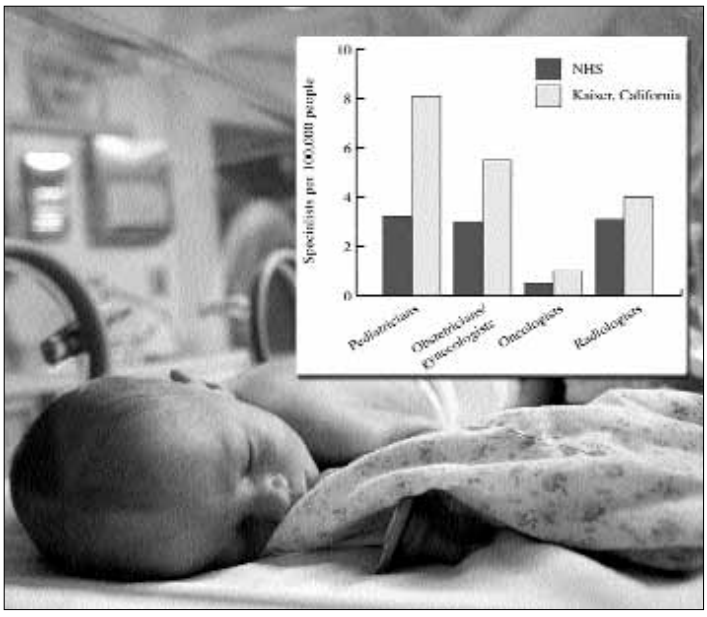
Richard Smith, editor of the *British Medical Journal*, writes about the study,

"It is a broad brush comparison between the NHS and Kaiser Permanente, a health maintenance organisation that cares for some 6.1 million Californians. The study finds that the two systems have similar resources but that Kaiser performs substantially better.

"In particular, patients from Kaiser have faster access to both primary and secondary care doctors. In other words, the widely held idea that the NHS albeit cheap is remarkably efficient may be wrong."

Smith continues, "Comparisons between systems are always difficult, and readers will rightly be sceptical, not least because they challenge a belief that is widely and deeply held in Britain. Our reviewers and editorial team started from that position but concluded that the results could not be explained by artefacts in the study or differences in the two populations."

"The conclusion that Kaiser performs much better for similar costs stands," concludes Smith. "Why? The [study] authors think that Kaiser may perform better because primary and secondary care are better integrated and the whole system better managed; because it has hospital stays a third the length of those in the NHS and much better information technology or because of competition."

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# English Health Care: Not Your Cup of Tea

HEALTH CARE continued from page 7

ing government policy because that's their job, regardless of any personal reservations they may have."

But the problem goes deeper than NHS managers blindly following their marching orders. Smith and Walshe state, "The truth is that this government has never trusted or respected [NHS] managers. It blames them for the poor state of the NHS (for example, dirty hospital wards and long waiting times in emergency departments) and doubts their competence. While NHS managers are used to being unloved by the public and health professionals, to find that their political masters have little regard for them leaves them isolated and disempowered."

### Leaving Home

One way to manage the ever-present health care queuing would be to take patients out of line and send them out of the country for their medical care.

The European Court of Justice has ruled the British government must provide treatment for patients abroad if it cannot ensure their timely medical care in the National Health Service. In response, the United Kingdom Department of Health has established a program for sending patients to other European countries for treatment.

If implemented, that effort could reduce the waiting lists for care. But it ignores the root cause of queuing and causes legal complications for the patient. Implementation of the program has been stalled, according to a report in the *British Medical Journal*, over concerns about the availability of legal redress for patients whose out-of-the-country treatment goes wrong.

In the U.K., roughly 90 percent of all medical negligence claims are financed by a government-funded legal aid system. It is the only European country to have such a program in place. But the plan provides coverage only for claims brought in U.K. courts, and therefore usually excludes claims against defendants located abroad. In Germany, by contrast, most people are covered by legal expenses insurance, which they can call on when a claim arises. Most other European countries have a similar system.

### Truth Rises to the Surface

The pressure on NHS managers to cut queuing is evident in a new government order to establish a "one strike and you're out" approach to patients who fail to keep appointments.

Like the "get out of the country" approach, this one ignores the root cause of long queues. Nevertheless, the Department of Health defended the tough approach toward no-shows, adding that mitigating circumstances would be taken into consideration. A spokesman noted: "Patients will see that this makes sense and it has been agreed with patient [focus] groups. If people simply do not turn up without a genuine reason, they will be sent back to their GP [primary care doctor]."

"This is laughable," said one GP, requesting anonymity, when I asked for an opinion. "This bloody well accomplishes nothing. It just moves the patient from one place in line to another place further down the line."

Details of the new edict emerged as the National Audit Office (NAO) released the results of an ongoing investigation of hospital trusts, aimed at determining whether they've been fudging the numbers when reporting their waiting lists. The NAO is an independent government agency that examines public spending on behalf of Parliament to determine the effectiveness and efficiency with which government bodies use public money.

The NAO issued a highly critical report, accusing nine trusts of "a major breach of public trust" for altering waiting list data to make it appear they had met government-recommended targets. In those nine trusts, 6,000 patient records had been manipulated to make waiting lists look shorter.

The NAO report explains many NHS trusts warranted investigation because a high number of patients have mysteriously dropped from the waiting lists.

> **"The NHS is, as Hobson would have it, 'an illusion of freedom of choice where there is no alternative.'"**

**For more information…**

**WWW** The National Audit Office's investigative report, "Inpatient and Outpatient in the NHS," is available on the Internet at **http://www.nao.gov.uk.**

Patients may be suspended or removed from lists legitimately if, for example, they become too ill to face a serious operation, get better on their own, seek their own private care out of the country, or die while waiting.

But in the case of many trusts investigated by the NAO, some suspensions were improper and simply designed to make the lists look shorter. The NAO said trusts should be investigated if more than 10 percent of their patients have been suspended from the waiting lists or more than 2 percent of their patients have been waiting more than 12 months.

One of the nine trusts named in the NAO report is the Royal United Hospital in Bath. Until recently, it was run by Barbara Harris, who was promoted to become director of the NHS Leadership Centre, also in Bath. The Centre is intended to exemplify and embody all that is best in NHS management.

Harris recently resigned from the NHS Leadership Centre position after the Commission for Health Insurance issued a report criticizing the way she ran the hospital. While further inquiries into financial management and accuracy of waiting list data at the hospital are underway, Harris will continue to work for the NHS in another capacity.

*Next month: Trying to fix the NHS.*

# Canadian Health Care Fails Five Ways

*Good health care rests on five pillars ... and they're not the "five principles" government officials espouse*

**BY DR. DAVID GRATZER**

Canadians demand certain basic characteristics in a health care system. They speak of the "five principles" of the Canada Health Act: public administration, accessibility, portability, comprehensiveness, and universality. But obsession with those principles largely misses the point.

Provincial portability may be nice, but it isn't as essential as timeliness of care. Portability between provinces is a regulatory agreement worth pursuing, but no one will die if portability is not enshrined in federal law and is instead left to the provinces to negotiate among themselves.

The defining characteristics of a health care system should speak rather to the basic pillars upon which good health care rests. The following are the five pillars of health care:

- Quality. Canadians need a health care system that provides quality medical care. The latest technology should be used to diagnose and treat citizens; medical facilities should be modern and well-equipped; physicians, nurses, and other providers should be highly trained and skilled.
- Timeliness. Illness should be diagnosed and treated quickly. Doing so makes economic sense, as long waits mean people are less productive. And timeliness is morally necessary, for forcing patients to wait in pain and anxiety for treatment is both cruel and wrong.
- Cost effectiveness. The system needs to produce acceptable results for the funds put into it. Precious resources must not be wasted on unnecessary procedures and unproductive administrators.
- Patient orientation. The health care system must exist to serve patients, not providers. Additionally, patients, not bureaucrats, must be the ultimate decision makers about their individual care. The choice of physician and course of treatment must ultimately rest with the patient.
- Accessibility. Regardless of financial circumstances, no Canadian should be deprived of the opportunity to get necessary medical care.

These five pillars are hardly controversial. But it's alarming to realize the extent to which the present system fails. On nearly each defining characteristic, Canadian health care—termed "medicare"—falls short.

### Quality

With limited funds available for investment in such capital expenditures as technologically advanced equipment and building maintenance and renovations, the quality of care has suffered in Canada.

Consider, for example, a straightforward arthroscopic surgery on the shoulder described in a 1997 article in the *Canadian Medical Association Journal*. The older equipment currently in use in the medicare system requires an incision of 15cm (6 inches). An incision of that length affects recovery time:

PILLARS continued on next page

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PILLARS continued from previous page

The patient will miss four months of work.

With state-of-the-art equipment, the same surgery would require only a tiny incision and a six-week recovery. In both cases, the shoulder heals ... but there's a clear difference in the quality of care.

### Timeliness

Timeliness doesn't simply mean emergency care is readily available. It also refers to the ability of the health care system to diagnose and treat illnesses promptly. Of course, no health care system is without delay, but there's a profound difference between heart bypass surgery being scheduled within a week and within a year.

Waiting lists plague Canada's system of health care delivery. A reasonable estimate is that tens of thousands of Canadians are waiting for some form of health care. Many of them are in pain, and some will die. In an annual international study by the Harvard School of Public Health, Canada distinguished itself by having the longest wait times for breast biopsies of five modern, industrialized nations surveyed.

**For more information…**

**WWW** David Gratzer's *Code Blue*—awarded the 1999-2000 $25,000 Donner Prize for best Canadian public policy book—is now in its fifth printing. The book can be ordered from Gratzer's Web site at **http://www.health-policyreform.org**.

### Patient Orientation

With the state as payer, the patient orientation of the health care system diminishes. For one thing, the doctor-state relationship replaces the doctor-patient relationship. To bill successfully, physicians must meet not their patients' needs, but the government's regulations.

In fact, the influence of the state extends to nearly every aspect of health care delivery. In the interest of "cost savings," medical developments—such as new treatments for the previously incurable tremor of Parkinson's or ultra-effective cancer agents—are not available.

And the state as payer means an artificial system of funding is created. Block funding to institutional providers (hospitals, for instance) means they have little incentive to concern themselves with the real needs of the communities they serve.

> **"[T]ens of thousands of Canadians are waiting for some form of health care. Many of them are in pain, and some will die."**

### Cost Effectiveness

Is Canada getting good value for the billions of taxpayers' dollars invested in medicare? With limited accounting practices and tracking of patient outcomes, it's impossible to determine medicare's cost-effectiveness. Nevertheless, it seems evident medicare isn't well organized.

Corruption of the doctor-patient relationship invites misuse of the system. Patients over-consume health services, and doctors over-provide those services. The bills add up. And the funding of institutional providers, allowing hospitals to function essentially as health care-providing cartels, is certainly ineffective.

### Accessibility

For financial accessibility, medicare seems to deserve a passing grade. Generally, Canadians are able to access the health care system without concern for cost.

The de-insurance of certain services and the introduction of limited user fees worry some because of their potential to threaten accessibility. For the most part, however, those concerns seem unfounded.

But to say our health care system is "accessible" is an equivocation of sorts. Financial circumstances, after all, won't keep an individual from getting the MRI scan he or she needs, but waiting lists and government guidelines can and do.

### Access to What?

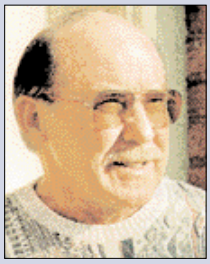
Yes, Canadians can marvel at the accessibility of medicare, but the question remains: "What do we have access to?"

One family doctor answers that question with examples from his own practice:

- a patient with liver failure who never had an "elective" admission, and whose spouse had to stay home from work to provide care;
- an elderly patient with acute renal failure who was never offered dialysis; and
- two patients needing spine operations who waited months for MRI scans.

*Dr. David Gratzer is a physician and writer. He is the author of* Code Blue: Reviving Canada's Health Care System *(ECW Press, 1999).*

## *Failings of Canadian Health Care Hit Close to Home*



**BY JACK KOENIG**

Thirty years ago I was dating a young doctor who was experiencing severe back pain. At the time, the "Papaya Treatment" was in vogue, and the place to get it done was St. James Hospital in Toronto, Canada.

Even with her credentials, my doctor friend had to wait seven months for an appointment. That wasn't because she was from the States, or because of high demand for the treatment ... and it certainly wasn't because of a lack of money on her part. It was simply due to the lack of medical personnel and facilities in Canada.

That was then, and this is now. Times have changed dramatically over that 30-year span, but not for the better: My younger brother Dan, a Canadian citizen, recently passed away from cancer. The cause of his death wasn't cancer per se, but rather the deteriorated state of the socialized Canadian health care system.

Approximately three years ago, Dan experienced severe stomach pains. After waiting four months to see his assigned physician, he was put in a queue for a barium study of his gastrointestinal track. Six months later, the study revealed Dan had an "unusual" growth in his stomach. He was placed in another queue to receive an MRI.

Eight months later, the MRI revealed tumors spreading throughout his system. Dan was scheduled for immediate surgery. Three months later the surgery revealed massive tumors spreading throughout his system. The physicians simply "sewed him up" and declared it would be a waste of resources to proceed further.

A little over a year later, Dan passed away, leaving his wife, three great teens, and one young adopted child.

Dan was chairman of the Sociology Department at Vancouver University. He also served on the board of directors for the Canadian Mounted Police. Yet even with all those credentials, he became a victim of socialized medicine, like so many other Canadians.

May he rest in peace.

*Jack Koenig is chair of Impact Voters of America.*

NOMINEE continued from page 1

officials, who expected the Massachusetts lawmaker to welcome the FDA nominee from his home state. "It would be unprecedented for anyone to be appointed from an industry regulated by the FDA, and now is not the time to start," Kennedy spokesperson James Manley told American Health Line.

### More Controversy

Vanderbilt University drug safety expert Dr. Alistair Wood is the latest controversial candidate. Senator Bill Frist, M.D. (R-Tennessee) has put his political muscle behind Wood, a fellow Tennessean. But pharmaceutical industry executives are giving the nominee thumbs down.

Industry executives see Wood as a potentially overly aggressive regulator, using as evidence a series of articles written by Wood and published in the *New England Journal of Medicine* and *Journal of the American Medical Association.* Wood's position on drug recalls and patient deaths led him to call for the FDA to be "more aggressive" in drug monitoring.

It's not only the pharmaceutical industry that rejects Wood as the best choice to head the FDA. Robert Goldberg, senior fellow at the Manhattan Institute, also thinks Wood is a bad choice.

**For more information…**

Dr. Alistair Wood's research and opinions have appeared in the May 12, 1999 issue of the *Journal of the American Medical Association* (page 1753) and the December 17, 1998 and October 12, 2000 issues of the *New England Journal of Medicine* (pages 1951-1954 and 1191-1194, respectively).

Writing in *National Review Online*, Goldberg notes, "What is remarkable is that while prescription drug use has increased in the past decade, the number of adverse events as a percentage of total prescriptions has hardly budged. Drug withdrawals [from the marketplace] as a percentage of new drugs remains at about 3 percent, essentially the same ratio from decades ago.

"Wood ignores this safety record," continues Goldberg. "Instead, he calls for companies to adhere to an impossible safety standard."

Asks Goldberg, "Like his cheering section in the Public Citizen, does he have contempt for private pharmaceutical profits that blinds and biases him against the right of companies to develop and market products based on their ability to make a clinical difference in people's lives?"

A January 17 *Wall Street Journal* editorial points out, "Dr. Wood argues for the prohibition on direct-to-consumer advertising until extensive post-market studies have been done to prevent 'the excessively rapid uptake of new drugs.'

"In other words," the editorial continues, "a cancer patient shouldn't be told of new treatments even after the hyper-cautious FDA has judged them safe and effective."

### "Against the Public Interest"

An executive for a leading pharmaceutical firm told *Health Care News*, "Dr. Wood is the original choice of former Vice President Al Gore and has won praise from Sen. Ted Kennedy, Ralph Nader, and Dr. Sydney M. Wolfe," who is director of the health research group for Nader's anti-business advocacy group, Public Citizen.

"Wood is on record saying the medical industry's research-intensive discovery of new medicines is less pressing than better regulation of the old ones; that more regulation, instead of more competition, is the recipe America needs; and that U.S. consumers' access to quality medicine is less important than lowering the price of medicines to the very poorest in society."

Without mentioning Wood, Dr. Henry Miller, writing in his book *To America's Health: A Proposal to Reform the Food and Drug Administration*, also warns against an FDA bent on over-regulation.

"It is in the public interest to spur innovation in the discovery, development, and marketing of new diagnostics and therapies, to stimulate vigorous competition among manufacturers, and to have an efficient system of oversight," Miller writes. "The current system of drug regulation is, literally, overkill, and it works against the public interest."

For reasons no one quite seems to understand, Republicans have failed to nominate a likely winner: Dr. David Sundwall, a former Reagan administration health official who has won praise from Kennedy and colleague Orrin Hatch because of his private medical work in Native American and Latino communities.

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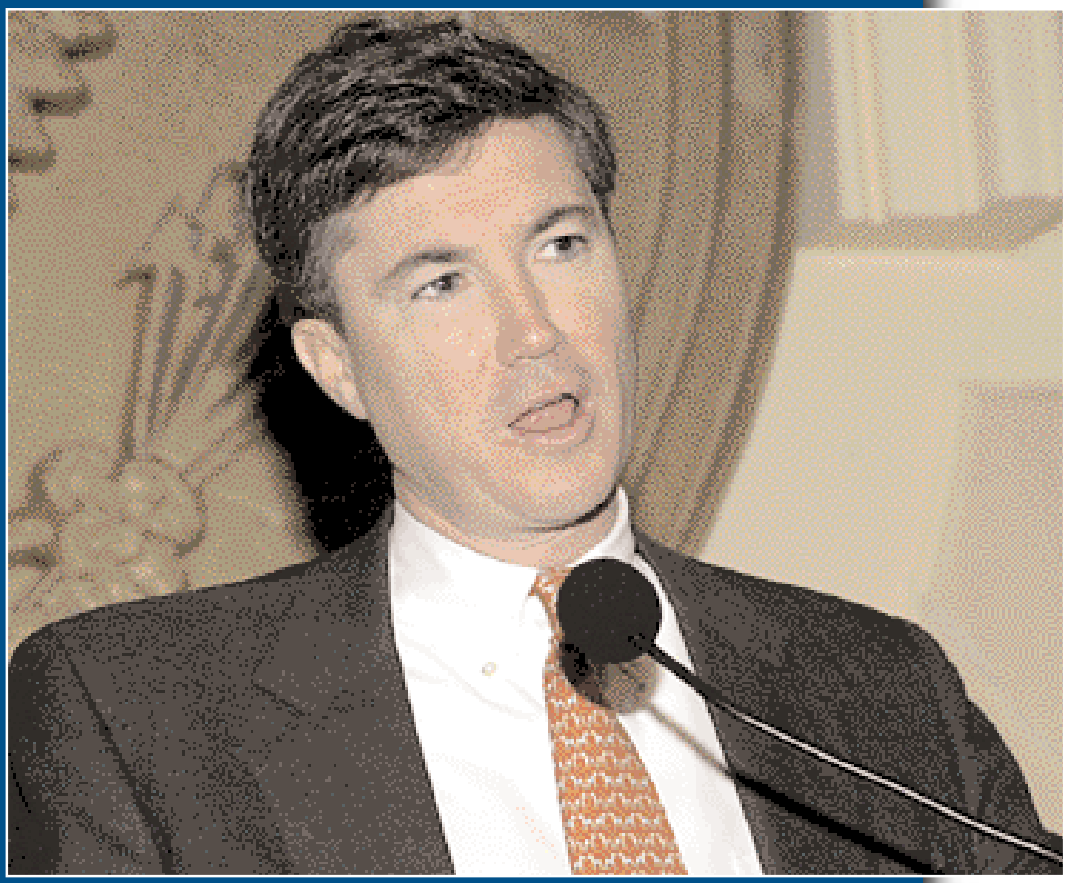

Photo: James Tkatch/www.tkactchphoto.com

**"I am now over here at the old HCFA because my boss Tommy Thompson hired me to shake it up, clean it up, and get it running so the first concern is the beneficiary, not the bureaucracy."**

**TOM SCULLY, ADMINISTRATOR CENTER FOR MEDICARE & MEDICAID SERVICES**

# NAHU Brings Free-Market Message to Capitol Hill

*Scully tells health insurance underwriters Medicare computers are "held together with bailing wire"*

**BY CONRAD F. MEIER**

The National Association of Health Underwriters (NAHU) held its 12th annual Capitol Conference on February 2-5 in the shadow of the nation's capitol. Over 600 health insurance agents and brokers heard some of the nation's most visible movers and shakers on health insurance-related issues.

Guest speakers included such noted figures as Tommy Thompson, secretary of Health and Human Services (HHS); Congressman Bob Ehrlich (R-Maryland), a candidate for the Maryland governorship; and Tom Scully, administrator for the Center for Medicare and Medicaid Services (CMS).

They were joined by Dennis Smith, CMS director on Medicaid and State Operations; Paul Harrington, senior health policy advisor to Senator James Jeffords (I-Vermont); Mark McClellan, who serves on the Bush administration's Council of Economic Advisors; and Congressmen Sam Johnson (R-Texas) and Ernie Fletcher (R-Kentucky).

### Politics and Health Care

Ehrlich spoke about the relationship between state and federal government policies and outlined several incompatibilities between the two.

"Any attempts at reforming Medicare" the Congressman noted, "are challenged by turf rules. For example, Medicare Part A comes under the jurisdiction of the powerful Ways and Means Committee, while Part B is under the control of the Commerce Committee." Ehrlich said Medicare reform should include combining Part A and Part B under one jurisdiction, but he expressed doubts anything will happen until one committee is willing to let go of some political power.

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Reform is further complicated, Ehrlich said, by the fact that state and federal legislators are really not reforming health care policy; rather, "we are manipulating the tax code."

Ehrlich also discussed the immediate future for MSA reform, saying "it is pretty much a non-starter due to the political philosophy of the Senate."

On the single-payer issue emerging in many states, including the major push in Maryland reported in *Health Care News*, the Congressman was emphatic: "If I am governor, those headlines will not appear in my newspaper." (See "Md. Single-Payer Proposal Would Cost 117,000 Jobs, Shrink Payroll Tax Receipts by $4.89 Billion," *Health Care News*, January 2002.)

"NAHU," Ehrlich warned, "is not as organized as the single-payer advocates are. The single-payer issue is politically attractive and will get a great deal of support from the media."

### Show Me the Money

Tom Scully proved, once again, to be a straight-shooter and likeable fellow. He immediately jumped the applause meter when he reminded the audience that prior to his CMS assignment, one of his primary jobs was to help kill the Clinton health care plan.

"I am now over here at the old HCFA," Scully promised, "because my boss Tommy Thompson hired me to shake it up, clean it up, and get it running so the first concern is the beneficiary, not the bureaucracy."

"Medicare needs to look and act like a modern health insurance policy that offers private options and covers prescription drugs outside of hospital care," Scully said. "People don't give a damn how they get the money, they just want health care."

Scully outlined some of his key goals for CMS:

- Teach beneficiaries more about health care choices and how to stay healthy;
- Reduce paperwork burdens for health care providers;
- Standardize claims processing and streamline forms; and
- Close the upper payment limit loophole that siphons off money for other health care needs.

One of many problems Scully is whittling away at is the Medicare computer system. The $150 million spent on the upgrade crashed. "We are holding our computer system together with bailing wire," he confessed.

### Insuring the Uninsured

In addition to the political "star-power" speakers, NAHU staff members themselves delivered fact-filled presentations on a variety of issues representing the main focus of the association: insuring the uninsured.

Kevin Corcoran, NAHU executive vice president, said NAHU continues to advocate a health care system that maximizes choice and promotes a robust and competitive market. He noted the group has been very active in finding creative, free-market solutions and has opposed heavy-handed government mandates.

"We are," Corcoran said, "also very concerned with any initiatives that add to the already rising cost of health insurance policies, pricing people out of coverage." Commenting specifically on so-called "patients' bill of rights" proposals, Corcoran noted, "The most important right is the right to affordable health insurance."

The three-day meeting was organized into topic sessions and breakout workshops conducted by NAHU staff members. NAHU members were given time in the afternoon to visit their Congressmen and lobby on behalf of NAHU issues.

Janet Trautwein, NAHU's director of federal policy analysis, laid out the focus of the conference, citing educational programs on insuring the uninsurable, defined contribution, high-risk insurance pools, private-sector planning for long-term care needs, genetic discrimination, and a "Prognosis for Domestic Health Policy."

As soon as Trautwein completed her conference duties, she was testifying at a hearing of the House Small Business Committee. Access to affordable health insurance is a key issue for NAHU at both the state and federal level. Trautwein explained to the committee that "access is a moot point if you can't afford to purchase a health insurance policy."

*Health Care News* Managing Editor Conrad Meier poses a question to one of the speakers during the NAHU conference.

### Cutting-Edge Sessions

Jessica Waltman, NAHU manager of health policy, provided members with a detailed update on state legislative activity, warning that state budgets awash in red ink will severely affect the uninsured rate.

Waltman explained how the Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative represents "one spoke in the wheel" that includes tax credits, MSAs, and high-risk pools as ways to address the uninsured population.

HIFA is a newly developed Medicaid and State Children's Health Insurance Program (SCHIP) section 1115 waiver approach. She pointed out that many states have not been successful in enrolling kids in SCHIP plans. In most cases, those states have had to return to the federal government their unspent SCHIP block grant money.

The HIFA initiative is a way to use currently available public funds in an effort to reach the non-Medicaid uninsured population by using the private individual and employer-based insurance market.

Kristin Fitzgerald, a staffer for the House Education and Workforce Committee, moderated a break-out session on a sleeper issue with grave ramifications, genetic discrimination. According to Fitzgerald, several groups from across the political spectrum want to prevent companies and insurers from using genetic testing. Republicans want to allow it, but only with modifications from current practice. The issue is now before the Senate's Health, Education, Labor and Pensions Committee.

Susan Rash, associate chair for employee benefits on NAHU's Legislative Council, moderated the defined contribution session. Representatives of defined contribution leaders Lumenos and Vivius made presentations that helped explain the defined contribution concept and the many ways it can be implemented.

### And the Oscar Goes To ...

NAHU awarded its highest honor, the Spirit of Independence Award, to Secretary Thompson.

In an inspiring acceptance speech, Thompson made crystal clear his dedication to providing better access and affordable health insurance for all Americans. Mentioning tax credits as one way to achieve that goal, he stressed the importance of making sure the money would be available monthly, when insurance premiums are due, rather than in a lump sum at the end of a tax year.

Thompson, in his closing remarks, made a solemn promise to make health care for all American citizens one of his top priorities during his tenure at HHS.

### President's Address

Bynum Tuttle, president of NAHU and an active insurance broker, offered closure to the Capitol Conference, saying "Our specific tasks in the coming years will take on many faces, but our purpose won't change. We're here to promote the best access there is to health care for all Americans. And we know you can't have the best access to care if you can't pay for it. We're here to be sure affordable private health insurance coverage remains available for everyone so they have the ability to pay for the health care they need."

**"Commenting specifically on so-called 'patients' bill of rights' proposals, [NAHU executive vice president Kevin] Corcoran noted, 'The most important right is the right to affordable health insurance.'"**

Tuttle also made a case for flexibility. "We know," he said, "as time passes, situations change, and the strategy we use to achieve our goals must also change. But as we look at each issue we face, we'll look at it with the goal of making a difference to those we serve. We'll continue to bring fresh new insight and share the reality of the real world with lawmakers, regulators, and others who may not have our experience in serving consumers and whose primary exposure may be just here in Washington."

Tuttle said his top priority for NAHU was to bring affordable private health insurance coverage to more people. He expressed confidence 2002 will be the year a refundable tax credit is signed into law. And he pledged to mobilize NAHU members in an effort to make sure the funds already available to states through the new HIFA waivers are used to provide the greatest number of people with private health coverage.

The meeting was concluded Tuesday evening with a by-invitation-only Congressional Reception at the Rayburn House Office Building.

NAHU represents over 17,000 professional health insurance agents and brokers who collectively provide health insurance protection for millions of Americans. Their expertise and daily experiences in the field have given NAHU members a level of credibility rarely seen on Capitol Hill. As one New Hampshire legislator is quoted as saying during a public hearing, "We are not going to make any decisions until we hear from health underwriters."

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# Poll: Long-Term Care Confuses Seniors

BY CONRAD F. MEIER

A new national survey conducted for AARP, the senior citizen advocacy group, finds few seniors grasp the real costs of long-term care, and they don't understand what their options are for paying that bill.

This lack of familiarity with the costs makes post-retirement planning difficult, say advocates for seniors. They want the government to devise a better system for educating seniors on these issues, including how to obtain long-term care insurance.

The survey, whose results were released in January, polled more than 1,800 people age 45 and over from across the country, as well as an additional 400 people in each of five target states: California, Florida, New Mexico, Washington, and Wisconsin. AARP leaders released the report in Florida because, they noted, the state is already experiencing senior-boom issues.

### Information Gap

While the national average monthly cost of a nursing home stay exceeds $4,600, only 15 percent of surveyed Florida residents came close to naming the right cost figure. Most significantly underestimated the cost. Florida residents had almost as much trouble identifying the $2,500-a-month cost of assisted-living care, according to the survey.

Advocates for seniors said the poll results surprised them. "If you do not know the reality, you cannot prepare for it," said Esther "Tess" Canja of Port Charlotte, Florida, national president of AARP. "For far too many people, the costs of long-term care will prove to be a crushing burden."

**For more information…**

**WWW** on the AARP survey, see the Executive Summary on the group's Web site at **http://research.aarp.org/health/ltc_costs_1.html.**

The Center for Long-Term Care Financing offers an informative Web site at **http://www.centerltc.org.** Its president, Stephen Moses, can be reached by email at smoses@centerltc.org.

Stephen Moses, president of the Center for Long-Term Care Financing, was less surprised by the survey results. "The problem with this survey," he told *Health Care News*, "and with the unending series of studies like it designed to blame long-term care problems on market failure—the ignorance and stupidity of consumers—is that it completely ignores the government role in long-term care.

"Consumers don't know who pays for LTC, nor do they care. But consumers are right, and the surveyors and experts are wrong, when they (consumers) give answers that suggest someone or something pays for LTC."

Most people surveyed mistakenly believe that "Medigap," a supplemental insurance policy filling gaps in Medicare coverage, will pay for a stay in an assisted-living facility.

Linda Barrett, a senior researcher for AARP, reported 31 percent of respondents said they had purchased insurance covering long-term care. But she noted the Health Insurance Association of America says only about 6 percent of Americans have the coverage. AARP officials suspect those people are probably confused about their policies, perhaps believing government health care or a private-sector health insurance policy provides extended long-term care benefits.

National demographic trends indicate these issues will become increasingly difficult to ignore. The number of residents over age 85 will increase 50 percent by 2010. By 2025, more than one of every four Floridians will be 65 or older. Nationally, 7 million Americans may need long-term care this year. By 2020, that figure will grow to 20 million.

> **"While the national average monthly cost of a nursing home stay exceeds $4,600, only 15 percent of surveyed Florida residents came close to naming the right cost figure."**

### Lack of Coordination

Despite the graying of its population, Florida has a disjointed system for handling important aging issues. At least six state agencies handle some aspect of long-term care concerns and funding, according to E. Bentley Lippscomb, AARP's Florida director.

Lippscomb, who ran the Department of Elder Affairs during Gov. Lawton Chiles' administration, has warned, "We're spending billions of dollars each year on long-term care, yet nobody is responsible."

AARP is backing a bill drafted by the State Senate Health, Aging and Long-Term Care Committee that creates a new oversight agency, dubbed the Office of Long-Term Care Policy.

### Benefit Enhancements

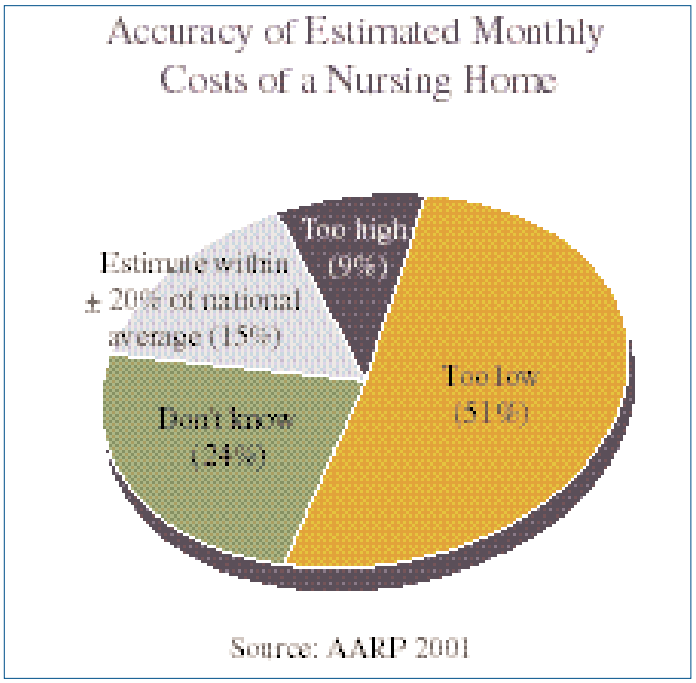
Long-term care insurance has been around since the 1960s but has never really caught on, experts say, because consumers don't see the need for it. The policies tended to be almost exclusively focused on nursing home care, an unattractive option to many seniors and their families.

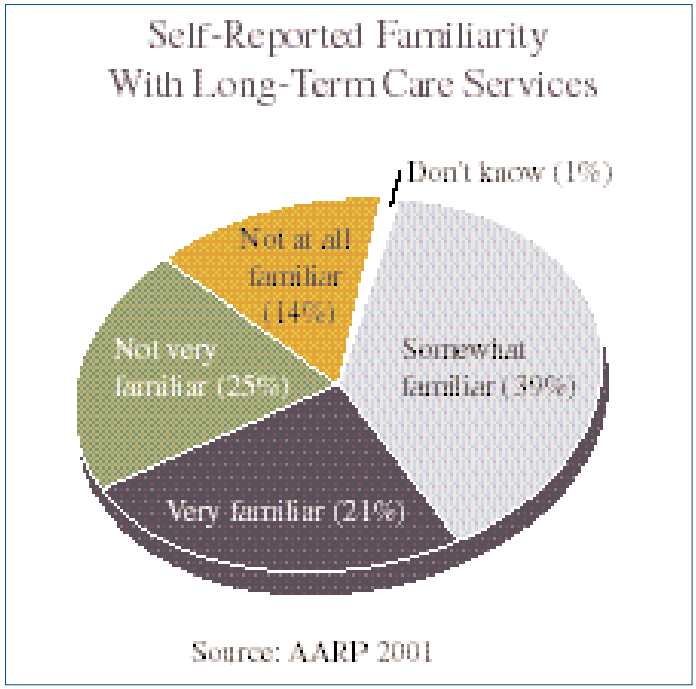
Interest in long-term care insurance is picking up, however. Today, many insurance companies give customers more choices, such as coverage for home health care or adult daycare. Some offer riders covering spouses or even parents who provide care for relatives.

As Moses explained, "The government-financed, welfare-based system created by perverse public policy incentives is in the latter stages of collapse. The public is starting to realize that to get access to quality care at the appropriate level, they must be able to pay privately.

"That's why you are finally beginning to see in the past 10 years some growth in the LTC insurance market and in private-pay alternatives to welfare nursing homes such as home care and assisted living."

Moses thinks AARP is right in concluding that today's LTC insurance policies are much better, but wrong about why people don't buy. "More education will help," said Moses, "but will not expand the market more than marginally. The key to getting people to buy private LTC insurance is to target scarce government LTC resources to the genuinely needy, and provide incentives for everyone else to plan early and save, invest or insure for the cost of long-term care."


Accuracy of Estimated Monthly Costs of a Nursing Home
Too high (9%)
Estimate within ± 20% of national average (15%)
Too low (51%)
Don't know (24%)
Source: AARP 2001




### Survey Methodology

The AARP survey was conducted by the Knowledge Management division of AARP's Membership Group under the direction of project manager Linda L. Barrett.

Survey respondents were selected randomly from a nationally representative random digit dialing (RDD) list. Respondents in the five target states were drawn from RDD lists for each state.

The national survey was conducted by telephone from July 20 through August 14, 2001; the state interviews were conducted by phone between July 27 and August 21. AARP reports the survey took an average of 16 minutes to administer.

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GALEN INSTITUTE

# THE GALEN REPORT

*A monthly review of health policy matters*

The contrast between modern consumer-oriented ideas to reform the health care system and tired centralized-control models came into sharp contrast again recently.

Senator Ted Kennedy, sadly, is dredging up failed ideas from the past. He said in a National Press Club speech in Washington that the federal government should mandate that all companies with more than 100 employees must provide health insurance to their workers.

The threat of an employer mandate was one of the death-knells of ClintonCare in 1994. Millions of employers do provide health insurance or added compensation because they want to do the right thing, but for some, these added and rising costs can make the difference between success and failure of the business. As long as they can provide the benefit voluntarily, the great majority will do so. A government dictate will never fly.

Right now, workers and employers are negotiating creative ways to give consumers more control over decisions and choices while helping to keep costs down. These innovations would never work under the thumb of government controls.

It's time for a change. For at least a decade, Washington political leaders have told us how terrible our health care system is. The message has gotten through. When I speak with Europeans, they believe we are just short of barbarians and are astonished to learn we don't actually leave people to bleed in the streets if they don't have health insurance.

The truth is, the United States still offers the world's best quality and most innovative health care. The change we need is to find creative new ways to get health coverage to millions of Information Age workers who are shut out of the system by antiquated Industrial Age policies.

### It's Personal

AMA President Dr. Richard Corlin talks about the quality of the American health care system in a column about his recent personal experience with emergency medical care for a growth in his lung.

"Every doctor, nurse, and health professional I dealt with was kind, caring and—above all—competent. And my health insurance paid for all of that first-rate care.

"My positive experience with everyday American medicine has given me an insight into correcting the issue of the uninsured. And that is, most of our health care delivery system is working very well, and should not be discarded under the guise of correcting the problems of the uninsured or any other aspects of health care that need our attention," he writes.

"Most prior efforts to insure the uninsured have failed because the desire has been to replace everything in our system with something new and untried. This scares off the large majority for whom the system works well. I think I always understood this lesson at an intellectual level. Now, through my own experience, I know it at a very personal and emotional level as well," he says.

This may signal an important shift in the AMA. Thanks to former AMA president and our valued colleague, Dr. Stormy Johnson, for alerting us to the column.

*For the full column by Dr. Corlin:* http://www.ama-assn.org/ama/pub/category/1690.html

— Grace-Marie Turner

## RECENT PUBLICATIONS

### The Iron Curtain Around Medical Progress

*Robert Goldberg*
*Health Affairs Book Review, January/February 2002*

After reading J.D. Kleinke's new book, *Oxymorons: The Myth of a U.S. Health Care System*, Robert Goldberg of the Manhattan Institute asks why "so many see medical progress and the private firms that produce medical technologies as the real threat to our health care system?"

In his book, Kleinke argues that "The only progress we make in health care is the progress we make in medicine." He describes an "Iron Curtain" of price controls, bureaucracy, and drug switching that limits medical innovation.

*Full text of book review:* http://www.health-affairs.org/freecontent/s38.htm

### Pfizer to Offer Drug Discount [Actually a Benefit] to Low-Income Elderly

*Robert Pear and Melody Petersen*
*The New York Times, 1/16/02*

Pfizer Inc. announced it has created a new "Share Card" program to offer its drugs to low-income seniors who don't have drug coverage for a flat fee of $15 a month for each prescription, much less than the average retail price of $65, reports *The New York Times*.

Pfizer Chairman Henry A. McKinnell said the company's program is intended to "bridge the gap in drug coverage until broader Medicare reform" is adopted. An estimated seven million people with gross incomes under $18,000 (for individuals) and $24,000 (for couples) could qualify for this program.

*Full text of article (requires free registration):* http://www.nytimes.com/2002/01/16/business/16DRUG.html

### CDC National Vaccination Plan Is Flawed

*Veronique de Rugy*
*The Cato Institute*

"Americans should be free to choose the smallpox vaccine if and when they want it," says Veronique de Rugy in an op-ed that first appeared in the *Atlanta Journal-Constitution*. She says that the current Centers for Disease Control and Health and Human Services plans are flawed, top-down approaches that could violate constitutional rights. A better approach would be to let individuals and doctors decide who should be vaccinated.

*Full text of article*: http://www.cato.org/research/articles/derugy-020110.html

### The Daschle Stimulus Proposal Ignores Unemployed Workers Who Lack Health Care Coverage

*Nina Owcharenko*
*The Heritage Foundation, 1/31/02*

The health coverage plan offered by Senate Majority Leader Tom Daschle would force most unemployed workers into the welfare program in order to receive health care benefits through the inefficient and expensive Medicaid program.

The proposal put forth by President George W. Bush and passed by the House before the Christmas break instead would give all displaced workers a refundable tax credit for 60 percent of the cost of premiums. Not only would the tax credit provide comprehensive and immediate relief for the unemployed, but it would also give them choices that the Daschle plan does not allow.

Owcharenko proposes going even farther by increasing the tax credit to 75 percent of the cost of the premium and allowing non-employer groups such as churches and nonprofit organizations to offer plans with the same tax benefits employers now receive.

*Full text of memo*: http://www.heritage.org/shorts/20020131health.html

*Material for this report is provided by The Galen Institute, P.O. Box 19080, Alexandria, VA 22320, http://www.galen.org. Grace-Marie Turner is president. This report is produced by Elizabeth Lamirand, who can be reached at 703/299-9550, and edited by Conrad F. Meier, managing editor of Health* Care News.

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Council for Affordable Health Insurance

February 11, 2002

Dear Legislator:

The economic slowdown will result in an estimated 1 million people losing their health insurance in 2002. In addition, health insurance premiums are going up, on average, about 15 percent, but many people and businesses are seeing increases in the 30 percent to 40 percent range.

Is there something that legislators at the state and federal levels can do? Yes, *avoid making the problem worse!*

Every year a small but vocal group of people calls on state legislators and Congress to "fix" the problems in the health insurance market. Almost every time elected officials have responded to those pleas, they have made the situation worse—increasing the cost of health insurance and the number of uninsured.

It is time for that to stop. The Council for Affordable Health Insurance, a research and advocacy organization promoting affordable health insurance, calls on elected officials to oppose legislation that would drive up the cost of health insurance. If anything, they ought to be adopting policies that make health insurance more affordable—such as greater access to Medical Savings Accounts and tax credits for the purchase of health insurance—not less so.

In order to identify the "Friends of Affordable Health Insurance," CAHI and numerous other organizations are asking elected officials to sign the pledge on the facing page. We intend to recognize, publicize and promote the names of those who say NO to laws that make health insurance more expensive.The pledge does not take a stand on any specific legislation; it takes a stand on principle.

If you support affordable health insurance, we ask you to sign the pledge form and send us a photocopy. If you'd like a handsome pledge certificate more suitable for framing, contact me and I'll have one sent to you.

We want to let everyone know who can be counted as a friend of the uninsured—and who only makes the problems worse.

Faithfully,

Merrill Matthews, Jr., Ph.D
Director

112 S. West Street, Suite 400, Alexandria, VA 22314 ◆ Phone: (703) 836 - 6200 ◆ Fax: (703) 836 - 6550 ◆ e-mail: mail@cahi.org
Website: www.cahi.org

Attention: State Legislators! Send your photo and we'll publicize your stand in *Health Care News!*
Mail to: The Council for Affordable Health Insurance, 112 S. West Street, Suite 400, Alexandria, VA 22314

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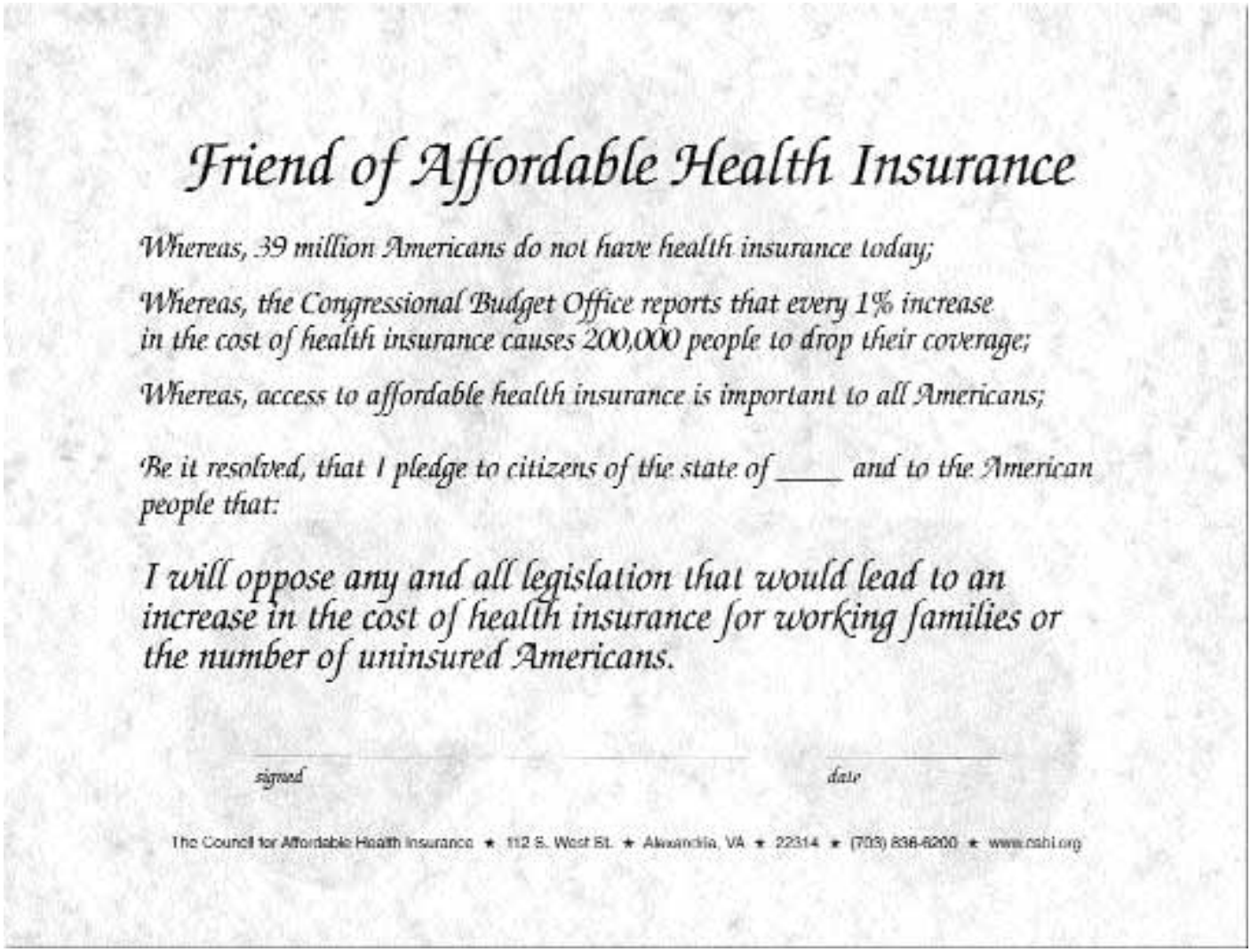

Friend of Affordable Health Insurance

Whereas, 39 million Americans do not have health insurance today;

Whereas, the Congressional Budget Office reports that every 1% increase in the cost of health insurance causes 200,000 people to drop their coverage;

Whereas, access to affordable health insurance is important to all Americans;

Be it resolved, that I pledge to citizens of the state of _____ and to the American people that:

I will oppose any and all legislation that would lead to an increase in the cost of health insurance for working families or the number of uninsured Americans.

signed _____ date _____

The Council for Affordable Health Insurance ★ 112 S. West St. ★ Alexandria, VA ★ 22314 ★ (703) 836-6200 ★ www.cahi.org

ADA continued from page 1

reasonably accommodate her disability and by terminating her employment.

When the District Court rejected her claim, Williams appealed. The Court of Appeals for the Sixth Circuit reversed the District Court, ruling in Williams' favor because her medical conditions "prevent[ed] her from doing the tasks associated with certain types of manual assembly line jobs, manual product handling jobs and manual building trade jobs (painting, plumbing, roofing, etc.) that require the gripping of tools and repetitive work with hands and arms extended at or above shoulder levels for extended periods of time."

Toyota appealed that decision to the U.S. Supreme Court, which granted certiorari in 2001.

### Good Facts, Good Law

Lawyers often say that "bad facts make bad law." Cases with odd, quirky factual scenarios can result in a decision that creates awkward precedent for subsequent cases with more straightforward facts.

The *Toyota* decision, by contrast, represents an example of good facts leading to good law. Even though Williams could not physically perform all of the manual tasks her job required (and indeed, there are probably many jobs she would not be able to perform), she had not established that she was substantially limited in performing "major life functions," as required by the ADA.

While the health problems that affected her ability to do her job at Toyota prevented her from doing some common, non-work-related activities, the Supreme Court noted "...she could tend to her personal hygiene and carry out personal and household chores." Accordingly, while her physical limitations may have prevented her from performing her job duties, they did not prevent her from doing many things that an average, healthy person can do.

As challenged as Ella Williams may have been by her medical conditions, she was not what the ADA's original champions had in mind when they lobbied for and passed the Act in 1990.

### Reasonable Interpretation

One of the ADA's principal advocates in the Senate was Bob Dole, a World War II soldier severely wounded in combat. Despite the loss of almost all function in his right arm, and the resulting ongoing pain, Dole graduated from law school and moved up the electoral ladder to the United States Senate.

Under the ADA, it is not enough for an employer not to discriminate against the person who can, despite physical limitations, fulfill the duties of his or her assigned job. The employer may be required to make changes in the workplace to ensure a person covered by the Act can do the job.

As the Supreme Court unanimously determined, the ADA applies when an employee has a "disability" that substantially limits one or more "major life activities." A disability that prevents a person from doing his or her job does not necessarily trigger the ADA.

When President George H.W. Bush signed the Americans with Disabilities Act into law, he called it "... powerful in its simplicity." The remarkable amount of litigation the Act has spawned would suggest he was overly optimistic.

But the High Court's January decision is a dramatic step in the right direction. The message it sends is clear:

"[T]he manual tasks unique to any particular job are not necessarily important parts of most people's lives. As a result, occupation-specific tasks may have only limited relevance to the manual task inquiry.... [H]ousehold chores, bathing, and brushing one's teeth are among the types of manual tasks of central importance to people's daily lives, and [should be] part of the assessment of whether respondent was substantially limited in performing manual tasks."

**For more information…**

**WWW** The full text of the U.S. Supreme Court's decision in *Toyota Motor Manufacturing, Kentucky, Inc., v. Williams* is available on the Internet, in both HTML and PDF formats, at **http://supct.law.cornell.edu/supct/html/00-1089.ZS.html.**

*Dewey L. Crepeau is a private practice attorney in Columbia, Missouri focusing on workers' compensation and Social Security Disability. He is a former assistant prosecuting attorney. Crepeau is also a contributing editor to* Health Care News. *He can be reached at dcrepeau@socket.net.*

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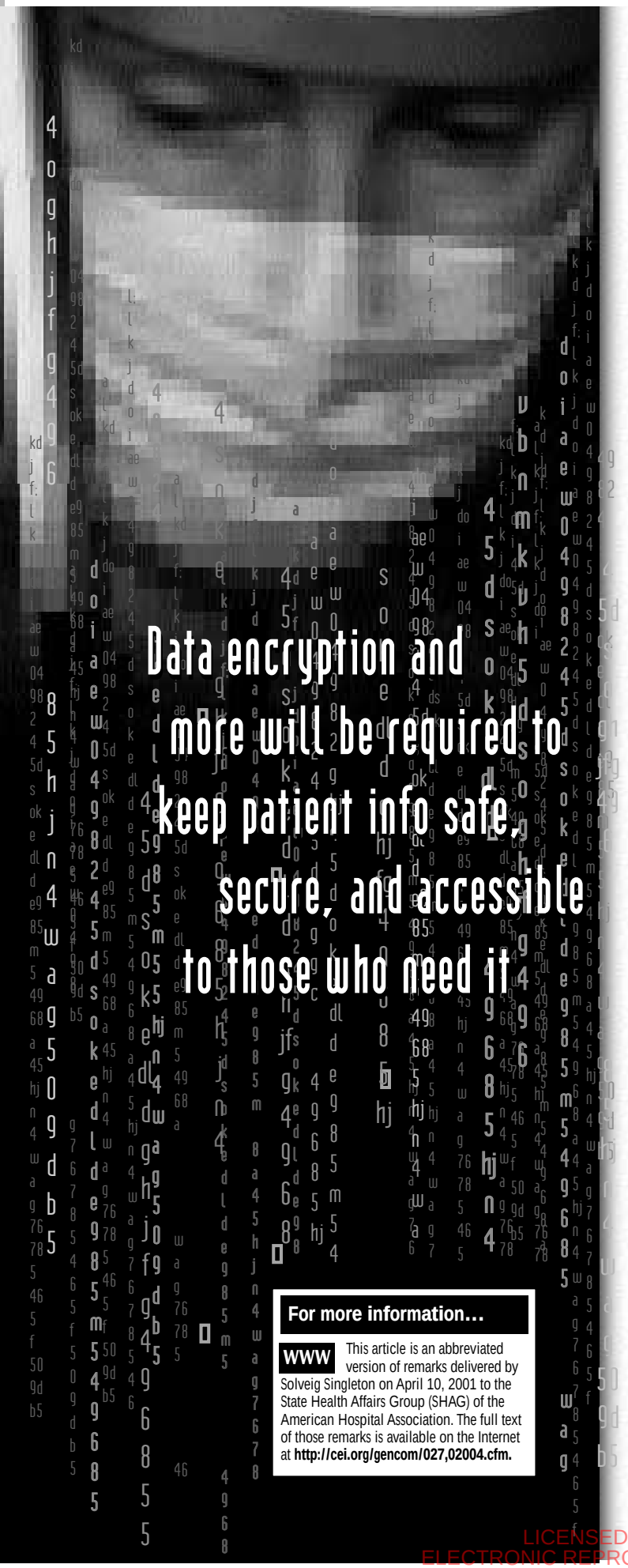

# HIPAA Ushers in New Era in Health Data Security

**Data encryption and more will be required to keep patient info safe, secure, and accessible to those who need it**

**BY SOLVEIG SINGLETON**

According to health industry analysts, compliance with new privacy and security rules passed as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will cost the nation's health-related businesses some $43 billion. Of that amount, nearly $25 billion will go to new computer hardware and software, along with training to implement the security provisions of the rule.

### New Model Needed

The old model of health care security is the "island" model. The data are stored in a network that can be accessed only by certain users, in certain special rooms, using certain special computers.

For the most sensitive information, that model probably will never be replaced. But for many health care applications it is already becoming obsolete, because caregivers and patients alike want access to medical records virtually upon demand, which requires a much more flexible system.

The "island" model does not work, for example, for doctors and patients exchanging email. Nor does it work for a doctor in the intensive care ward who wants to access a patient's treatment history on a wireless device while standing next to that patient's bed. Nor would it work to secure large files of data in transit to a third party on a different network, such as an insurance company.

For all these reasons and more, the heightened security available through data encryption will become increasingly important in future health care transactions.

### Encryption and Security

Encryption uses very hard math to encode the text of a document into code. In order to transform the document back into readable "plaintext," one must know the key to the code. The type of encryption most likely to be used for email and in digital signatures uses what is called a Public Key Infrastructure.

In a Public Key system, there are two keys: a "public" one and a "private" one. The two keys are related to each other by a complex mathematical formula. The public key is publicly posted, often on the Internet, for everyone to see.

The private key is known only to the user. If the user wants to send an encrypted message, he encrypts it with the private key. The recipient can decrypt it with the public key. To reply, the recipient can use the public key to encrypt her response, and the end user decrypts the text using his private key.

The longer the string of digits used in the key, the more difficult it is to break the encryption (assuming the encryption has no other flaws, so that the only method to break it is by trying every possible key—a "brute force" attack).

The keys planned for use to create digital signatures will be either 512 or 1,024 bits long. But a computer expert announced last fall he had designed a computer called "Twinkle" that could crack one type of 512-bit key in around three days. Military applications now use 1,024-bit keys.

### HIPAA Security Rules

HIPAA's new security rules require that hospitals control access to patient files and install systems to authenticate the identity of caregivers accessing the files. The rules also require new security measures, so that stored data or data in transit are protected by security systems that ensure:

- message integrity—that the message is not altered in transmission;
- non-repudiation—to prevent the signer of a message from later disavowing it; and
- authentication—to verify that the user and recipient are who they claim to be.

The new model involves encrypting the content of a network behind a firewall to create virtual private networks (VPNs). Highly secure networks may use 13 or more layers of encryption. These private networks are connected to the Internet and can be

**For more information…**

**WWW** This article is an abbreviated version of remarks delivered by Solveig Singleton on April 10, 2001 to the State Health Affairs Group (SHAG) of the American Hospital Association. The full text of those remarks is available on the Internet at **http://cei.org/gencom/027,02004.cfm.**

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SPENDING continued from page 1

an annual rate of 1.9 percent in 2001 and are expected to remain stable in 2002.

According to a survey by Hewitt Associates, half of the 700 organizations surveyed across the United States said that over the next five years, the maximum added annual cost they can absorb for health care benefits is 8 percent.

Worse still, health insurance agents and brokers in the field say the 13 percent figure cited by Mercer does not reflect the entire health insurance market. That figure, they say, is from large corporations with deep pockets who can absorb some of the inflation.

Members of the National Association of Health Underwriters (NAHU), at a Washington conference held February 2-5, said their individual and small group insurance clients are being hammered with up to 30 percent increases.

### Why Costs Are Rising

Fueling the inflation in health care costs are the combined effects of unfunded state and federal government regulations on insurers, such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA); state patient's rights laws that are unraveling the cost-control efforts of HMOs and PPOs; increased consumption of non-generic prescription drugs; increasing demands for long-term care by an aging population; and physicians who have regained some pricing leverage with health plans.

The rising cost of medical care is trickling down to workers in the form of higher premium contributions and other costs, such as larger deductible amounts before insurance coverage kicks in, and larger co-payments at each doctor visit and on each prescription filled. Higher health insurance costs to employers also mean smaller wage increases or even lay-offs.

During the days when unemployment was at historic lows and the economy at full tilt, U.S. companies were eager to attract and keep their best workers by absorbing much of the impact of higher medical costs. Today, facing shrinking profits and an upward trend of operating costs, employers look to shift more of the responsibility to their employees, health care industry experts say.

### MSA-Style Options

Employees will be asked to take a greater role in managing their own medical expenses under so-called consumer-directed initiatives that give workers more choices of plans and options as an incentive to keep costs under control.

One new plan targeted to younger and healthier workers provides basic preventive care and catastrophic coverage at a lower monthly premium, but with relatively high deductibles. More employers are looking at multi-tiered co-payments and deductibles for prescription drugs, doctor office visits, and hospital stays.

Dr. Jonathan Lord, chief clinical strategy officer for Humana Inc., one of the insurers testing several new plan designs, suggests, "The more engaged people are in choosing their benefits, the more I believe they will have confidence in their health plan."

Abbott Laboratories Inc., a maker of hospital products and pharmaceuticals, is including some 40 health plan offerings next year in a pilot plan with a flexible spending account of $1,000 for singles and $2,000 for families.

The new twist is in how Abbott employees can spend the money on health care not traditionally covered by insurance, such as laser eye surgery. As is common with medical savings accounts, any leftover funds can be carried over to the next year and accumulated for future health care needs.

General Motors Corporation, the nation's largest private purchaser of health insurance, is actively encouraging its workers to select generic drugs. GM rates its health plan providers by how well they are controlling costs and whether their health providers offer a high level of quality of care. Employees are given a "report card" on its health plan providers so they can compare providers and choose the one best suited to their needs.

Also expected to grow in popularity are programs assisting employees in managing chronic health problems such as diabetes, arthritis, and obesity.

### Free-Market Solutions

According to the insurance professionals at NAHU, the current premium inflation trend presents an opportunity for government to expand the use of market-oriented options. Agents and brokers say there is a surge of interest in Medical Savings Accounts, tax credits, and defined contribution plans.

Given the recent extension of the enrollment period, MSAs offer individuals and small group employers hard hit by premium increases an opportunity to buy affordable health insurance. To date, the MSA option has helped thousands of Americans gain affordable, portable tax-favored insurance coverage.

NAHU was quick to support tax credits as a market-based opportunity to buy MSAs or other health plans in the private market, noting the credits offer immediate assistance to the uninsured and under-insured. Tax credits also create a fair system that ensures progress toward the goal of universal coverage through incentives rather than government mandates.

Defined contribution (DC) also offers a new direction in health care coverage. As premium inflation continues, DC plans are being implemented by an increasing number of employers large and small. Some NAHU agents and brokers say the traditional employer health benefit remains intact, while the employee savings in premium cost can be as much as 25 percent.

The added bonus in the DC approach is that employees, not their employers, choose the plan that best suits their individual and family needs.

accessed from anywhere ... but only if you are an authorized user with the right password or fingerprint or typing pattern.

### Encryption Policy Questions

The use of encryption has most often raised policy questions at the federal, rather than state government, level. For years, encryption was regulated by national security agencies as a type of "munition."

Most of the debate about encryption policy concerned whether to lift the limits on exporting strong encryption software to other countries. There never were any limits on the strength of encryption that could be used within the United States.

> **"Compliance with new privacy and security rules ... will cost the nation's health-related businesses some $43 billion."**

Nevertheless, limits on export hindered the development of domestic encryption for health care purposes. Software developers were not eager to invest in developing one product for the U.S. market and another for export. Within the past two years, however, the rules on exporting encryption have been relaxed, especially for health care applications.

HIPAA does not preempt the adoption by states of even stricter privacy rules. For example, the HIPAA security rules are technology neutral. They do not stipulate the use of particular software or hardware, or prefer one type of encryption over another. Some states might choose to abandon that policy and prescribe a particular technology.

Another looming issue is how institutions will remain HIPAA-compliant over time.

Suppose a hospital installs a firewall and access control system that uses 512-bit or 1,024-bit encryption. The hospital does its best to be up to, or even slightly ahead of, the industry standard. But the day after its system is installed, a brilliant mathematician in New Zealand or Israel comes up with a way to crack the code and announces his results to the world. Would the hospital be HIPAA-compliant on Monday but not on Tuesday? How will judges or regulators view compliance when the standard set by the technology is such a moving target?

### Weakest Link

In terms of HIPAA compliance or compliance with other security requirements, encryption will probably be necessary ... but it won't be sufficient.

Encryption is best used to stop hackers or other unauthorized persons from accessing health records. But it cannot stop an employee with authorized access from abusing his privilege to access information, or from violating that confidence out of sheer carelessness.

The best remedy, of course, is to have in place a compliance program that emphasizes accountability and establishes appropriately strong penalties for employees who breach obligations of confidentiality.

*Solveig Singleton is a lawyer and senior policy analyst on technology and innovation for the Competitive Enterprise Institute (CEI). His email address is ssingleton@cei.org.*


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My Turn

# Happy Birthday to Us!

**BY CONRAD F. MEIER**
**MANAGING EDITOR**

*Health Care News* celebrates its first birthday this month! Like most infants, we've grown by leaps and bounds, thanks to the tender loving care and devoted attention of scores of parents, aunts and uncles, kissing cousins, and generous friends.

### Why We're Here

*Health Care News* was launched out of frustration with the way the general media addressed important public policy issues.

Explains Heartland President Joseph Bast, "Reading a typical daily newspaper, you would never know there is a major 'tug of war' taking place right now between those who want more government regulation of health care, and those who want less. Or that the past few years have yielded real data proving that heavy-handed regulation and increased subsidies lead to rising costs and less access to care ... the opposite of what 'progressive' reformers promised."

### A Team Effort

I have found it truly gratifying to receive your emails and phone calls offering congratulations, support, and thanks. Many of you realize *Health Care News* is a team project, but for those of you who don't, I'd like to call your attention to the many people who work behind the pages:

> **"Like most infants, we've grown by leaps and bounds, thanks to the tender loving care and devoted attention of scores of parents, aunts and uncles, kissing cousins, and generous friends."**

- Heartland President Joe Bast is the visionary here. He keeps me focused not only on the big picture, but also on the key pieces to the puzzle. As importantly, he communicates the soundness of our vision and the righteousness of our approach to donors ... without whom *Health Care News* would remain merely an idea.
- Vice President Diane Bast, as editor of *Health Care News*, keeps my writing simple, accurate, and on deadline.
- Publisher Nikki Saret sets the deadlines Diane enforces; pitches the newspaper to potential advertisers; and promotes the newspaper to subscribers at scores of conferences across the country.
- Circulation Manager Latreece Vankinscott makes sure subscribers get what they're supposed to get, when they're supposed to get it. She also manages a strong, multi-tasking staff ready to assist anyone—subscriber, writer, advertiser, or even managing editor—with anything. My personal thanks to Toria Jones, Beola Leonard, and Cheryl Parker.
- Greg Lackner, Heartland's public affairs director, promotes *Health Care News* through Internet contacts as well as the mainstream media. He's responsible for putting Assistant Editor Merrill Matthews, a Heartland senior fellow, "on the road" to promote health care reform at meetings across the country.

### What You See

*Health Care News* benefits from the regular contributions of many of the reform movement's brightest lights. Assistant Editors Merrill Matthews and Greg Scandlen, and contributing editors Grace-Marie Tuner, Tom Miller, Dewey Crepeau, Dr. Miguel Faria, Gerry Smedinghoff, and Twila Brase have all made valuable contributions to the publication's content.

And then, of course, there's the Heartland art department, which packages the stellar *Health Care News* content into a readable and compelling graphic presentation. Without the talents—and sheer hard work—of Art Director Kevin Fitzgerald and Design Assistant Jen Beranek, I wonder how many of you would even consider picking up the newspaper?

### Last ... But Certainly Not Least!

With all that appreciation I've just expended on my "supporting cast," you might wonder if there's anyone left to thank.

But of course there is and that's you!

Your support for this newspaper—your comments, your moral support, and your financial contributions alike—is, in the end, what keeps this whole enterprise going.

All of us at *Health Care News* have worked hard to earn your approval ... and we will continue to do so. *Please let me know* whenever we fail to live up to your expectations (and, as importantly, when we exceed them!). I really do appreciate hearing from you. I'm easily reached by email (meier@heartland.org), or by phone at 573/445-3023.

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